



Grand Challenge
Responding to the Addictions Crisis

Legal and Policy Best Practices in Response to the Substance Abuse Crisis

A PRELIMINARY REPORT



Indiana University Grand Challenge: Responding to the Addictions Crisis

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March 30, 2018

Table of Contents

Executive Summary	4
Introduction	7
Background	9
Methodology	12
Findings: Overarching Themes	19
Findings: Specific Law and Policy Interventions	22
1. Harm Reduction	22
2. Healthcare Interventions	28
3. Care Coordination and Wrap-Around Services	35
4. Drug Take Back Programs	39
5. Patient Privacy Protections	41
6. Courts	45
7. Proceeds from Opioids Litigation	50
8. Stigma	54
Concluding Remarks	59
Appendices	60
Appendix A: Research Team Biographies	60
Appendix B: Disclosure to Interviewees	62
Appendix C: Sample Questions	63

Prepared by:



Nicolas P. Terry, BA (Law), LLM
Hall Render Professor of Law
Executive Director, William S. and Christine S. Hall Center for Law and Health
Indiana University Robert H. McKinney School of Law at IUPUI

Ross D. Silverman, JD, MPH
Professor of Health Policy & Management
Indiana University Richard M. Fairbanks School of Public Health at IUPUI
Professor of Public Health & Law
Indiana University Robert H. McKinney School of Law at IUPUI

Aila Hoss, JD
Visiting Assistant Professor and IU Grand Challenge Fellow
Indiana University Robert H. McKinney School of Law at IUPUI

Rebecca Critser
JD/MA Candidate 2018
Indiana University Robert H. McKinney School of Law at IUPUI

Emily Beukema
JD/MPH Candidate 2021
Indiana University Robert H. McKinney School of Law at IUPUI
Indiana University Richard M. Fairbanks School of Public Health at IUPUI

Catherine Sterling, MPA
MPH Candidate 2019
Indiana University Fairbanks School of Public Health at IUPUI



EXECUTIVE SUMMARY

In 2017, Indiana University, in cooperation with Indiana Governor Eric Holcomb and community partners, launched the Grand Challenge: Responding to the Addictions Crisis initiative, a university-wide effort to advance interdisciplinary research and interventions in response to the substance abuse crisis affecting Indiana and the nation. The “Legal and Policy Best Practices in Response to the Substance Abuse Crisis” project is one of sixteen funded under Phase 1 of the Grand Challenge. This preliminary report outlines the initial findings of the project.

Specifically, this report describes the results of a qualitative study that surveyed individuals with expertise related to the substance abuse crisis in Indiana for their thoughts and perspectives on effective law and policy interventions. Based on this information and additional original research, this report also analyzes select law and policy areas identified as promising interventions to combat the substance abuse crisis in Indiana. The report identifies general or medium-term law and policy issues, a list of specific findings that may be appropriate for more immediate action, and a suggestion of topics requiring further research across eight categories:

Findings	Government Level		
	Federal	State	Local
Harm Reduction, Preliminary Report p. 21			
Repeal requirement that bystander immunity be linked to administration of overdose intervention drugs		*	
Extend overdose immunity to individual needing medical assistance		*	
Extend overdose immunity to include more violations		*	
Extend overdose immunity to individual possessing a syringe from a syringe exchange program		*	
Implement safe station programs		*	*
Healthcare Interventions, Preliminary Report p. 27			
Provide resources to better integrate syringe exchange programs with other treatment and services	*	*	*
Provide evidence-based treatment to Indiana's jail population		*	*
Provide wrap-around services to those in recovery or during re-entry	*	*	*
Evaluate needs of addictions and healthcare workforce	*	*	*
Look beyond existing intervention models and explore potential for county or regional rapid stabilization models of care		*	*
Reduce administrative barriers to receiving Medicaid services	*	*	



Care Coordination and Wrap-Around Services, Preliminary Report p. 34			
Allow prisoner re-entry, safe and supportive housing, vocational services, and other wrap-around services to qualify as Medicaid reimbursable products	*	*	
Evaluate provision of wrap-around services for 6-12 months for SUD individuals who successfully complete a treatment program		*	
Reexamine premium requirements, administrative requirements, and penalties such as lock-outs and negative HIP tiering for persons with SUD to reduce care coordination costs		*	
Consider making additional waiver requests from CMS to provide care coordination and wrap-around services that lead to Medicaid savings	*	*	
Fund demonstration projects to examine novel approaches to providing coordinated care for SUD population	*	*	
Examine feasibility of delaying introduction of HIP eligibility and maintenance of benefits reforms as they apply to SUD population until crisis shows signs of abatement		*	
Reinstate Medicaid services for incarcerated individuals 30 days prior to their release		*	
Drug Take Back Programs, Preliminary Report p. 38			
Develop, implement, and support more flexible local take back programs		*	*
Patient Privacy Protections, Preliminary Report p. 40			
Clarify limited role of "psychotherapy notes" provision, and instruct providers that it does not justify a refusal to share substance use or mental health records	*		
Clarify how "emergency" carve-outs in the two regulations operate and provide detailed instructions on how to navigate them	*		
Identify and promote specific, lawful data-sharing frameworks and technical workflows that minimize barriers caused by the differential protections	*		
OCR and SAMHSA should issue explicit joint enforcement guidance that minimizes clinicians' concerns over legal implications of dealing with these privacy laws	*		
Courts, Preliminary Report p. 44			
Assess the knowledge, attitudes, beliefs, and behaviors of those working in the court systems related to MAT and SUD		*	
Evaluate the variation in entry requirements for the state's drug courts		*	
Update assessment of the decade-old, limited outcomes evaluation of Indiana's state drug courts		*	
Explore effectiveness of using the Indiana 2-1-1 system to aid in identify area inpatient and community-based treatment options for those with community-based sentences and/or probation		*	

Identify and evaluate court policies addressing the interaction of judges with pharmaceutical and medical device representatives		*	
Proceeds from Opioids Litigation, Preliminary Report p. 49			
Support inclusion of language in any opioids settlement that directs the majority of settlement funds be spent on treatment and health care related to opioid addictions		*	*
Pass legislation that commits the state to responsible and relevant "best practices" expenditures that prioritize substance use harm reduction, treatment, and education		*	
Stigma, Preliminary Report p. 53			
Encourage education campaigns directed toward providers, as well as the public, on MAT and naloxone	*	*	*
Assess impact on knowledge, attitudes and beliefs of Indiana Supreme Court educational program in July 2018 for those who work in court system		*	
Policymaking bodies should, whenever possible, include the voices of those directly impacted by SUD, including family members and current or former SUD service recipients	*	*	*

INTRODUCTION

The Grand Challenge

In 2017, Indiana University (IU), in cooperation with Indiana Governor Eric Holcomb and community partners, launched the Grand Challenge: Responding to the Addictions Crisis initiative, a university-wide effort to advance interdisciplinary research and interventions in response to the substance abuse crisis affecting Indiana and the nation.¹

The lives of countless Hoosiers are being devastated by addiction. Heroin overdoses are at an all-time high. Prescription painkillers are being abused at alarming rates. To put this national epidemic in perspective, more people now die from drug overdoses than died from HIV/AIDS at its peak in 1995.

Addiction does not discriminate—it affects all of us, including our friends, colleagues and loved ones. Without a swift and comprehensive effort, this public health crisis—both in Indiana and around the country—will continue to endanger the health of our families, our businesses and our communities.

The three overarching goals of the Addictions Crisis Grand Challenges initiative are to:

- Reduce the incidence of substance use disorders (SUD);
- Decrease opioid deaths; and,
- Decrease the number of babies born with neonatal abstinence syndrome (NAS).

The Grand Challenge seeks to leverage the strengths of IU in the following domains: (1) data sciences and analytics; (2) education, training, and certification; (3) policy analysis, economics, and law; (4) basic, applied, and translational research; and (5) community and workforce development.

This Project

The “Legal and Policy Best Practices in Response to the Substance Abuse Crisis” project is one of sixteen funded under Phase 1 of the Grand Challenge: Responding to the Addictions Crisis initiative and focuses on law and policy. The project team consists of researchers at the IU Robert H. McKinney School of Law (McKinney Law) and IU Richard M. Fairbanks School of Public Health (FSPH) at Indiana University-Purdue University Indianapolis (IUPUI; see Appendix A: Research Team Biographies). Researchers investigated and analyzed the content and implementation of local, state, and federal laws and policies related to the substance abuse crisis and conducted interviews with key stakeholders with expertise related to these law and policy concerns. Informed by the evidence collected, the project’s primary goals were to identify and assess opportunities to improve the effectiveness of Indiana law and policy implicated in the State’s response to the substance abuse crisis.

As noted above, the causes of the current crisis are multifactorial. Research has identified effective policies and programs, implemented at an array of intervention points, that may reduce substance

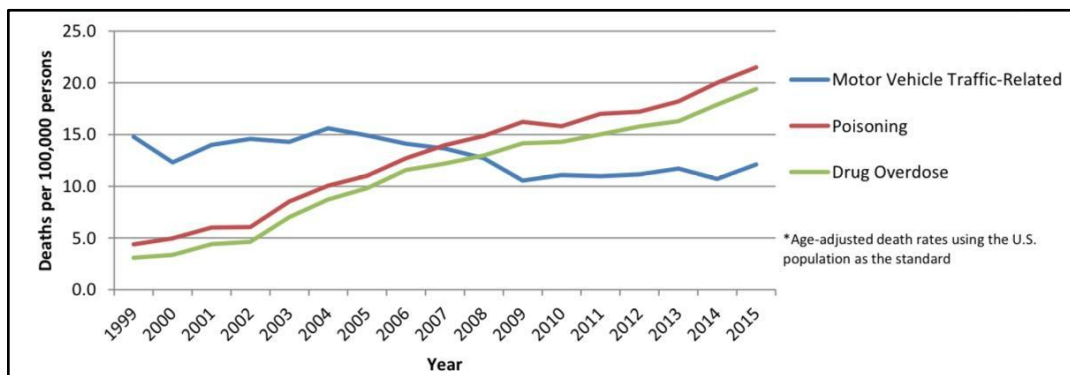
¹ *Grand Challenges: Addictions*, IND. UNIV., <https://grandchallenges.iu.edu/addiction/index.html> (last visited Mar. 25, 2018).

abuse and/or the adverse effects of substance abuse on health and society. However, how lawmakers, and those who interpret and implement laws, define and identify problems, set priorities, and invest in legal and policy responses, often deviate from the research evidence. Their actions tend to be mediated by divergent political, professional, and personal philosophies and language.

The report identifies general or medium-term law and policy issues, a list of specific findings that may be appropriate for more immediate action, and a suggestion of topics requiring further research.

BACKGROUND

A study by the Center for Health Policy (CHP), a research hub of the FSPH Department of Health Policy and Management, found nearly one in twelve Hoosiers—almost a half million people—meet the criteria for having an SUD.² Approximately four thousand Hoosiers have died from opioids in the last decade,³ and the drug-induced mortality rate in Indiana quadrupled between 2000 and 2014.⁴ In 2015, the Indiana State Department of Health (ISDH) reported the overwhelming number of poisoning deaths in Indiana were caused by overdoses and far exceeded vehicular traffic-related deaths.⁵ In addition to this preventable loss of life, the economic cost of drug overdose deaths to Indiana in 2014 was estimated at \$1.4 billion.⁶



The substance abuse crisis is a rapidly moving target. For example, recent literature based on emergency department data on overdoses, published by the Centers for Disease Control and Prevention (CDC), demonstrates a considerable worsening of the substance abuse crisis, including a sharp spike in the Midwest, particularly in Indiana.⁷

Note: The phrases “opioid abuse” and “opioid abuse crisis” are part of the larger substance use disorder (SUD) and substance abuse crisis research covered in this report. While interchanged periodically, all phrases touch on the same project focus. Additionally, interviewees spoke on opioid abuse when specifically discussing the substance abuse crisis in both Indiana and the United States.

² HAROLD KOOREMAN & MARION GREENE, TREATMENT & RECOVERY FOR SUBSTANCE USE DISORDERS IN INDIANA, IND. UNIV. CTR. FOR HEALTH POLICY 16-H80 (Lyndy Kouns ed., 2016), available at <https://fshp.iupui.edu/doc/researchcenters/Treatment%20and%20Recovery%202016.pdf>.

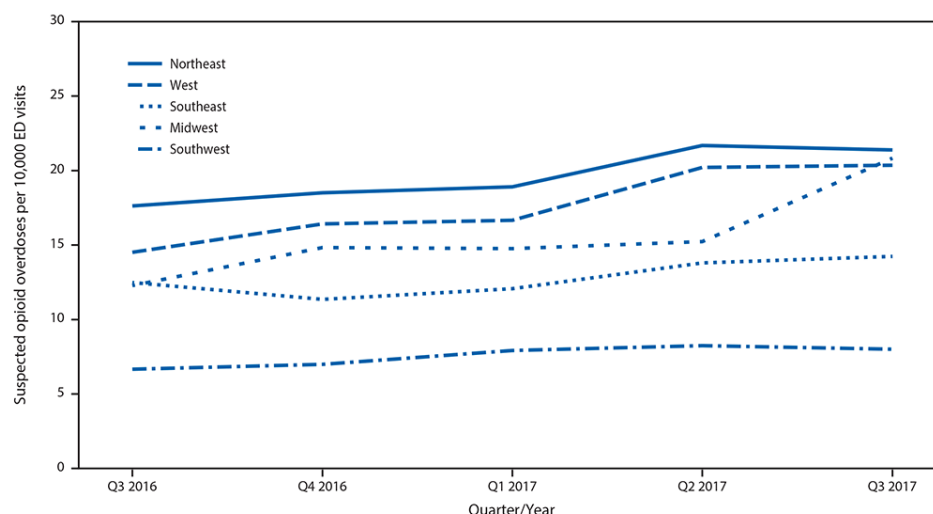
³ Bob Segall, *So Many Bodies: Indiana Coroners Trying to Keep Up with Opioid Epidemic*, WTHR (Nov. 15, 2017, 7:14PM), <https://www.wthr.com/article/so-many-bodies-indiana-coroners-trying-to-keep-up-with-opioid-epidemic>.

⁴ HAROLD KOOREMAN & MARION GREENE, TREATMENT & RECOVERY FOR SUBSTANCE USE DISORDERS IN INDIANA, IND. UNIV. CTR. FOR HEALTH POLICY 16-H80, 4 (Lyndy Kouns ed., 2016), available at <https://fshp.iupui.edu/doc/researchcenters/Treatment%20and%20Recovery%202016.pdf>.

⁵ DIV. OF TRAUMA AND INJURY PREVENTION, *SPECIAL EMPHASIS REPORT: DRUG OVERDOSE DEATHS, 1999-2015*, IND. STATE DEPT. OF HEALTH (2017) https://www.in.gov/isdh/files/2017_SER_Drug_Deaths_Indiana.pdf.

⁶ JOAN DUWVE, ET AL., REPORT ON THE TOLL OF OPIOID USE IN INDIANA AND MARION COUNTY, RICHARD M. FAIRBANKS SCH. OF PUB. HEALTH (2016), available at <https://www.inphilanthropy.org/sites/default/files/Richard%20M.%20Fairbanks%20Opioid%20Report%20September%202016.pdf>.

⁷ Alana M. Vivolo-Kantor et al., *Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017*, 67 MORB. MORTAL. WKLY. REP. 279 (2018), available at <http://dx.doi.org/10.15585/mmwr.mm6709e1>.



Not only are these numbers in flux, but the sources of the problem and so, to an extent, the possible solutions continue to evolve.⁸ Over-promotion, overprescribing, and diversion of prescription opioids were significant contributors to the current substance use crisis. However, as indicated in the chart below, the crisis increasingly revolves around the abuse of non-prescription opioids by non-medical users. Further, the substance abuse crisis goes beyond opioids, with the United States Drug Enforcement Administration (DEA) recently reporting a significant spike in the availability and use of cocaine, and methamphetamine traffic from Mexico on the rise nationwide.⁹

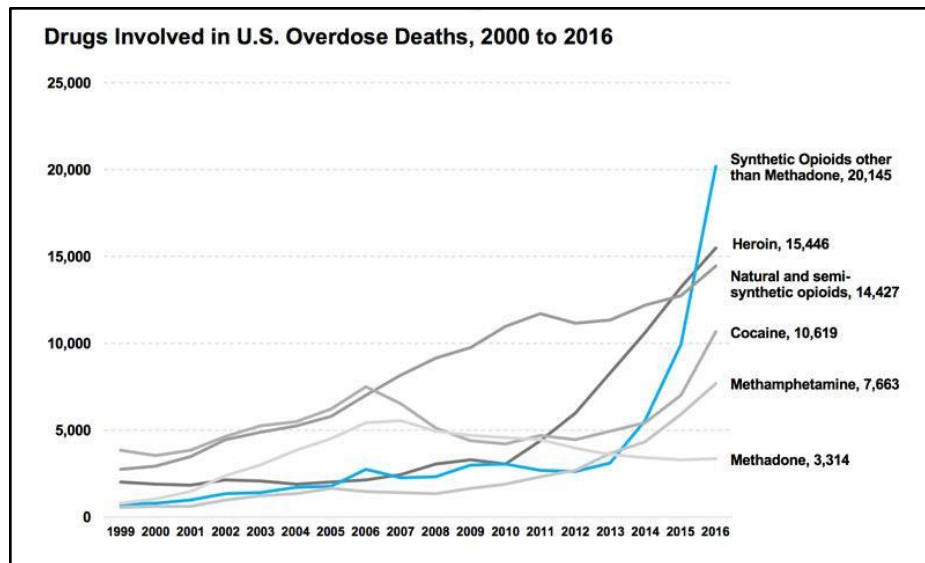
Indeed, this preliminary report's research and detailed views of interviewees are consistent with one evolving view of the substance abuse crisis; there exists not just one crisis, but two:

The first is the prescription-drug epidemic—highly visible to the public, and more likely to occur among older adults in rural, white communities who misuse prescription painkillers. The second, more recently emerging epidemic, is among younger adults who are victims of illegally produced opioids such as fentanyl. Urban communities of color have recently witnessed a surge in deaths resulting from these illegally produced opioids.¹⁰

⁸ *Overdose Death Rates*, NATIONAL INSTITUTE ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates> (last updated Sept. 2017).

⁹ DRUG ENFORCEMENT ADMINISTRATION, 2017 NATIONAL DRUG THREAT ASSESSMENT, DEA-DCT-DIR-040-17 (2017), <https://www.dea.gov/docs/DIR-040-172017-NDTA.pdf>. See, also, Peter Phalen et. al., *Fentanyl related overdose in Indianapolis: Estimating trends using multilevel Bayesian models*, (ADDICT. BEHAV. Forthcoming 2018), available at <https://www.sciencedirect.com/science/article/abs/pii/S0306460318301217>; Christine Vestal, *A New Meth Surge Gathers Momentum*, THE PEW CHARITABLE TRUSTS (May 18, 2017), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/05/18/a-new-meth-surge-gathers-momentum>.

¹⁰ Shanoor Seervai, Arnav. Shah, & Eric C. Schneider, *The U.S. Has Two Opioid Epidemics: The Federal Response Should Consider Both*, TO THE POINT (Mar. 22, 2018), <http://www.commonwealthfund.org/publications/blog/2018/mar/federal-response-to-opioids>.



As the research team moves forward and considers legal and policy changes to combat these crises, it is important to account for whether suggested changes address both crises, or only one.

METHODOLOGY

This section describes the methodology used to develop this preliminary report, including the combination of prior research, interviewee data, and original research. Project scoping and design also are addressed.

Prior Expert Reports

In narrowing down topics for detailed study, the research team drew upon and analyzed prior national reports on the opioid and overarching substance abuse crises. In particular, the research team assessed and compared findings from *The 2016 Surgeon General's Report*,¹¹ *the 2017 President's Commission on Combating Drug Addiction and the Opioid Crisis*,¹² and the *2018 National Governors Association Recommendations for Federal Action to End the Nation's Opioid Crisis*.¹³

This project's research also benefited immeasurably from studying the report from Governor Holcomb and Executive Director for Drug Prevention, Treatment, and Enforcement Jim McClelland, *A Strategic Approach to Addressing Substance Abuse in Indiana*¹⁴ and its accompanying *Action Plan*,¹⁵ and the earlier work of the *Indiana Prescription Drug Abuse Prevention Task Force*.¹⁶

Expert Interviews

The team conducted qualitative research by holding semi-structured interviews with an array of subject matter experts on laws and policies implicated in the substance abuse crisis response. The goal of these interviews was to 1) enhance the insights found during the independent research phase and 2) identify near-term, medium-term, and long-term opportunities for—and obstacles to—law and policy reform that would better align current response efforts with evidence-based and evidence-informed best practices.

IU Institutional Review Board Approval

Prior to beginning the expert interview process, the research team submitted an exemption application for the qualitative study with the IU Institutional Review Board (IRB), including the interview procedures,

¹¹ *Early Intervention, Treatment, and Management of Substance use Disorders*, in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, 4-1, 4-10 to 11 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

¹² *The President's Commission on Combating Drug Addiction And The Opioid Crisis* (Nov. 1, 2017), Office of National Drug Control Policy, President's Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/>.

¹³ *Governors' Recommendations for Federal Action to End the Nation's Opioid Crisis*, NATIONAL GOVERNORS ASSOCIATION, 5 (Jan. 18, 2018), https://www.nga.org/files/live/sites/NGA/files/pdf/2018/OGR/Governors%27%20Recommendations%20for%20Federal%20Action%20to%20End%20the%20Nation%27s%20Opioid%20Crisis_0118.pdf.

¹⁴ *A Strategic Approach to Addressing Substance Abuse in Indiana* (2017), IND. GOVERNOR'S OFFICE, <http://www.in.gov/gov/files/A%20Strategic%20Approach%20to%20Addressing%20Substance%20Abuse%20in%20Indiana.pdf> (last visited Mar. 29, 2018).

¹⁵ *Indiana Drug Prevention, Treatment and Enforcement Preliminary Action Steps*, IND. GOVERNOR'S OFFICE (May 18, 2017), <http://www.in.gov/gov/files/DPT%20Preliminary%20Action%20Steps.pdf>.

¹⁶ INDIANA PRESCRIPTION DRUG ABUSE PREVENTION TASK FORCE, *TAKING ACTION: THE FOUR YEAR REPORT 2012-2016*, available at <https://www.in.gov/bitterpill/files/FINAL%20Four%20Years%20In%20Action%20Report%20%20OAG%20Coverchange%20final.pdf>.

study information sheet, and sample interview questions. The exemption application was approved (IRB Study #1712454963, Protocol Exempt, Dec. 15, 2017).

Interviewee Identification

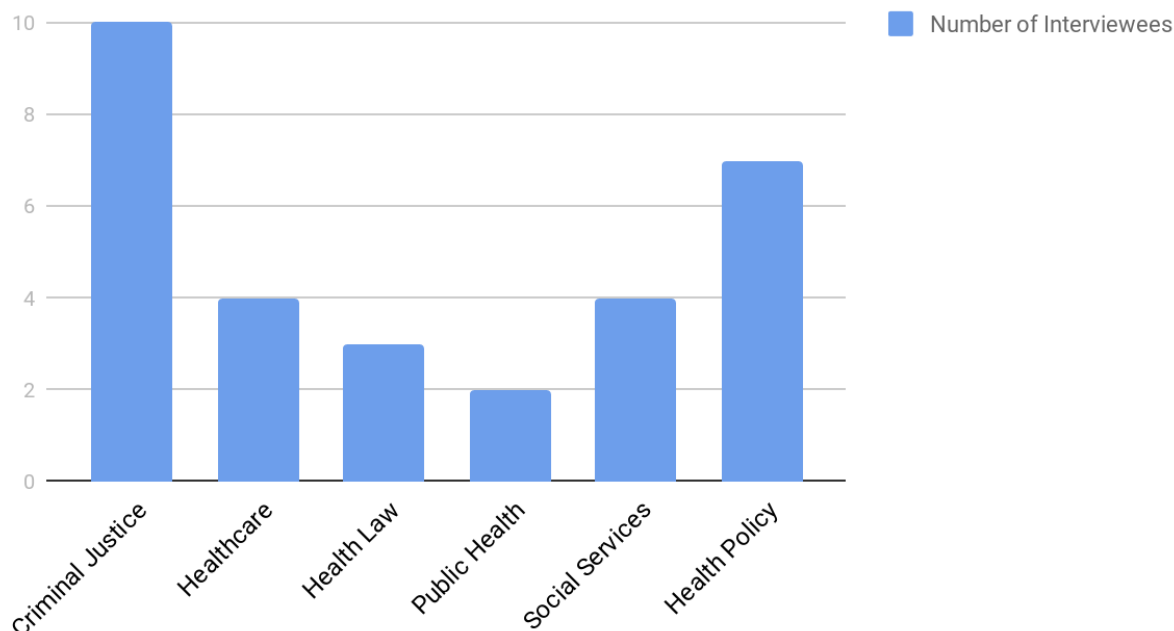
Interviewees were identified using a variety of channels. The research team first connected with their existing network of researchers, practitioners, and policymakers with expertise in the substance abuse crisis. These individuals were either invited to be interviewed or were asked to identify potential interviewees. Additionally, as part of some formal interviews, interviewees provided, or were asked to provide, additional recommendations.

The research team selected their interviewees following substantial discussion of the individuals' substantive areas of expertise (e.g., public health, criminal justice, healthcare) and their role in responding to the substance abuse crisis (e.g., state government official, researcher, insurer). The interviewee selection process aimed to secure breadth in the roles and expertise of these individuals. The initial project goal was to conduct interviews with at least 12 experts. Ultimately, the research team conducted 20 semi-structured interviews. Some interviews involved multiple persons. Not included in the data below are the multiple informal discussions held with leaders of the judiciary, state government officials, and other researchers, which served as background information for the research team.

Interviewee Areas of Expertise and Role in Response

Interviews were conducted with 20 key experts. The interviewees have been categorized into the following domains of substantive expertise (Figure 1), with some experts qualifying in multiple categories:

1. Criminal Justice
2. Healthcare
3. Health Law
4. Public Health
5. Social Services
6. Health Policy

Figure 1: Interviewee Substantive Expertise (inc. multiple expertise)

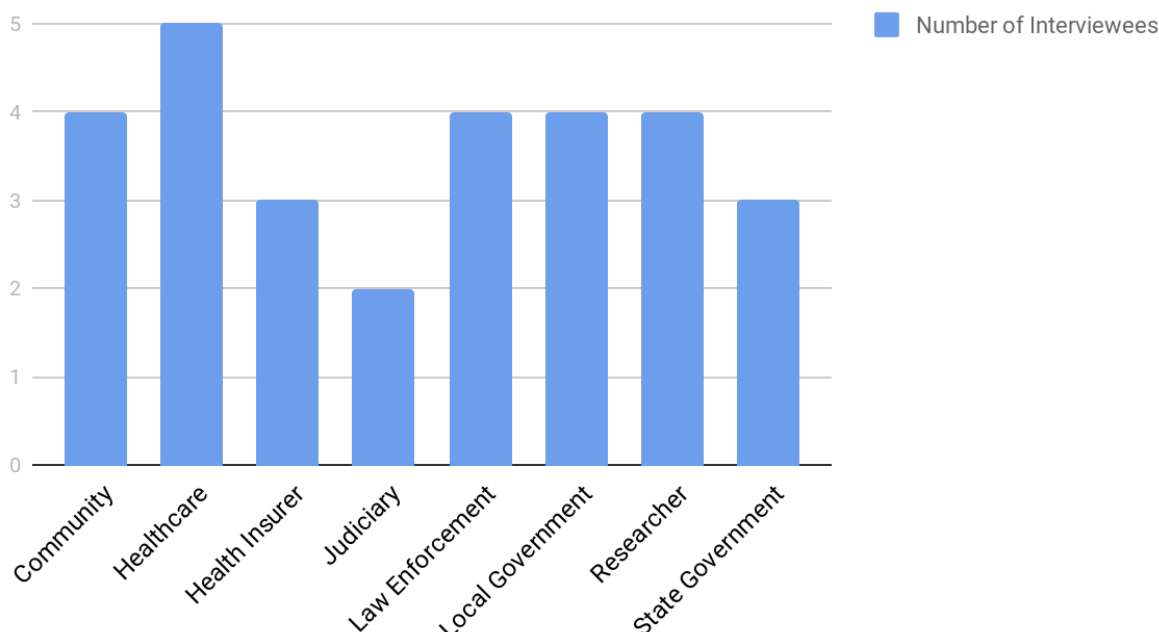
The role or roles each interviewee plays in the substance abuse crisis response varied across nine categories. Some experts covered more than one category, as shown in Figure 2:

1. Community Agency
2. Healthcare Provider
3. Health Insurer
4. Judiciary
5. Law Enforcement
6. Local Government
7. Researcher
8. State Government

In the interview selection process, two limitations were noted. First, the research team had a relatively short time frame to conduct interviews (mid-January to mid-March 2018). It therefore was imperative that the team be strategic in selecting individuals. Thus, comprehensiveness in the expertise areas and roles of interviewees could not be achieved. Second, although the goal was to pursue broad representation in role and expertise of interviewees, the team recognized this process is subject to

selection bias and cannot represent all individuals with expertise and experience with law and policy barriers relating to the substance abuse crisis.

Figure 2: Interviewee Roles (inc. multiple roles)



Interview Process

Once identified, interviewees were sent a formal invitation to participate in the study. The invitation included a study information sheet (*Appendix B: Disclosure to Interviewees*), outlining the purpose and procedures of the study. Interviews were conducted in person, via conference call, or via video conferencing. The interviews lasted between 30-75 minutes, with most interviews lasting between 45-60 minutes.

Interviews were semi-structured. The research team directed a common set of open-ended questions to all interviewees and customized additional questions for each interviewee based upon their particular areas of expertise. See *Appendix C: Sample Questions* for sample interview questions.

Original Research

Using information collected from academic scholarship, prior expert reports, and key interviews, the team identified areas meriting additional research. Researchers utilized the Indiana General Assembly web site (iga.in.gov) and subscription-only legal research databases (*WestlawNext* and *LexisNexis*), to collect relevant statutes, regulations, and case law, as well as PubMed and search engines to collect scientific literature and information from state and federal agencies. The goal of this research was to identify and analyze evidence-based and evidence-informed substance use crisis-related law and policy interventions.

Scoping

From the inception of this project, the team was fully cognizant that not only was the research following in the footsteps of others who have examined these issues at both the federal and state level, but also that currently in Indiana, this team is not the only group working on these issues. The team is familiar with and continually impressed by the positive steps taken by Governor Holcomb's *Commission to Combat Drug Abuse*, members of the Indiana legislature, the leadership of Indiana's court system, and the ongoing research of the Pew Charitable Trust, as well as innumerable initiatives led by state and local agencies, law enforcement, healthcare providers, charitable organizations, communities, researchers, and many committed individuals.

Those agencies or individuals that work or research issues related to substance abuse long ago knew that they face a "wicked problem." Using this frame, an addictions medical doctor recently described the opioid crisis as follows:

Those who advocate for reducing opioid prescribing fail to see the Ohio experience where opioid use simply went underground or shifted to illicit drugs. Those who advocate for no adjustment to opioid prescribing fail to see the correlation between prescribing and overdoses observed in many communities. Those who argue that this is purely a problem of social determinants of health fail to see the overdose and addiction rates in affluent communities. Those who argue that medication assisted treatment (MAT) will solve the problem fail to see that most patients who are prescribed MAT do not continue it, and in fact relapse to opioids . . . Those who push an access-to-care argument fail to see that access is just the first step – we need appropriate utilization of resources. Those who are going after the "opioid crisis" fail to see that over 50% of opioids in the US are prescribed to people with mental health conditions and unless we treat those underlying mental disorders, we cannot solve this problem.¹⁷

The *Strategic Approach to Addressing Substance Use in Indiana* report noted how the effectiveness of society's response to the multifaceted substance abuse crisis will be governed in large part by the implementation, application, and enforcement of local, state, and federal law. The complex nature of this challenge includes, but is not limited to, addressing laws and policies related to mental health and addiction, criminal justice, child welfare, healthcare access and delivery, public health, education, public safety, and community engagement and resilience. Furthermore, research shows this crisis represents a syndemic, with multiple diseases and social determinants combining to create a complex web of intertwining challenges.

The stakeholders involved in the response have widely varying backgrounds and experiences, both professional (criminal justice, healthcare, public health, law, non-governmental organizations, education, elected and non-elected government work, social science research) and personal (individual, familial, and community-lived experiences responding to the epidemic). These varying perspectives affect the way the parties define, identify, and prioritize problems associated with the substance abuse syndemic, as well as how they identify and measure success. Additionally, policies and laws passed and

¹⁷ Jonathan C. Lee, *The Opioid Crisis is A Wicked Problem*, 27 Am. J. Addict 51, 51 (2017), available at <https://onlinelibrary.wiley.com/doi/epdf/10.1111/ajad.12662>.

implemented to address substance abuse crisis challenges may result in the emergence and/or identification of previously unforeseen or underappreciated new challenges.

The substance abuse crisis is one of the most complex challenges affecting the health of Indiana residents of all ages. An effective response to the problem requires evidence based and evidence informed multidisciplinary collaborations. As experts in healthcare law and policy, public health law, health data, and ethics, the team recognizes the unique role of law and health in the epidemic. The structure, interpretation, and application of laws and policies can act as impediments to evidence-based approaches to the substance abuse crisis. Equally, well-crafted laws and policies may offer opportunities to positively resolve the epidemic.

Even after the application of narrower frames, such as law, policy, or public health, the scope of the problem and potential solutions are almost immeasurable. As a result, the team decided to narrow the scope of the project's inquiry, conscious of each individual's skill sets (expertise in and prior research on the public health system, healthcare delivery, healthcare data, and legal epidemiology). Additionally, many recent national and state reports have identified the same "low-hanging fruit," including amelioratory measures designed to remedy the genus of legal barriers or associated policies that are the subject of this study. These measures have become "table stakes" in state efforts to combat the substance abuse crisis. Indiana has taken notable steps, moving past issue identification to implementation with regard to several of these proposals, by:

- Making naloxone broadly available and increasing the number of persons who can administer it, in large part thanks to *Aaron's Law*,¹⁸
- Improving data management through initiatives, such as those led by the Data Management Hub, with the shared goal of improving data sharing among agencies and producing actionable information designed to help public health and other authorities address new outbreaks or concentrated hot spots;¹⁹
- Expanding Prescription Drug Monitoring Programs (PDMP) to provide better information to prescribers and pharmacists, increase prescriber obligations to consult a PDMP during care delivery, and improve integration of PDMP in provider workflows by, for example, integrating the data into electronic health records (EHRs). Indiana is moving on these issues with, for example, changes to its INSPECT program and EHR-integration provided by Appriss Health;²⁰
- Establishing supply-side approaches to reducing the number of opioids in circulation, such as by placing limits on the prescription of opioids (as Indiana has done²¹), increasing physician education, and changes in reimbursement policy;
- Increasing policing and other law enforcement efforts to reduce the supply of illegal drugs. This research team fully accepts that a major issue in the substance abuse crisis, both nationally and in Indiana, is the supply of illegal or diverted drugs.²² Indeed, the team recognizes the increased

¹⁸ *Programs and Initiatives*, OVERDOSE LIFELINE, INC., <https://www.overdose-lifeline.org/programs-and-initiatives.html> (last visited Mar. 25, 2018).

¹⁹ *Management Performance Hub, Opioid Epidemic*, STATE OF INDIANA, <http://www.in.gov/mph/930.htm> (last visited Mar. 29, 2018).

²⁰ INDIANA PROFESSIONAL LICENSING AGENCY, INDIANA TO INTEGRATE PRESCRIPTION DRUG MONITORING PROGRAM STATEWIDE (2017), *available at* <https://www.in.gov/pla/files/Statewide%20Integration%208.24.17.pdf>.

²¹ IND. CODE § 25-1-9.7-2 (2018).

²² The President's Commission on Combating Drug Addiction And The Opioid Crisis 58-65 (Nov. 1, 2017), Office of National Drug Control Policy, President's Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

supply of non-prescription drugs has been a crucial accelerant in the crisis and, as noted above, more overdoses are now caused by illegal drugs than prescription drugs. These findings support the continual and growing imperative of interdiction and enforcement. Additionally, the criminal law issues related to the substance abuse crisis are themselves evolving. For example, one interviewee noted “a huge increase in theft, shoplifting, prostitution, home invasions, carjacking—all to pay for drugs.” Other interviewees from the judiciary and law enforcement confirmed these trends.

- Notwithstanding, in general, there are relatively few legal or policy *barriers* to interdiction or enforcement (though clearly there may be resource constraints). Rather, criminal law and criminal justice constructs tend to flow in the opposite direction, creating barriers to some of the interventions that are discussed later in this report. In particular, many interviewees were critical of increased attempts to further criminalize aspects of the crisis. As one interviewee said, “we’re not going to arrest our way out of this, yet we still criminalize.” One interviewee from Indiana law enforcement reiterated that “being an addict is not a crime;” another noted that the role of law enforcement officers had changed to harm reduction and, increasingly, to introducing those with SUD to treatment.
- However, while the team has sought to strike the right balance between appropriate criminal enforcement and harm reduction, it also is acutely aware that, in Indiana, stakeholder views, public perceptions, and public policy are still evolving.

Several interviewees expressed strong opinions on Indiana’s adoption or implementation of some of these table stakes initiatives. These perspectives may be issues the research team returns to examine and assess later in this research project.

FINDINGS: OVERARCHING THEMES

As prior reports were analyzed and interviews were performed, the team was impressed by the commitment of persons from all domains to make a positive difference in the substance abuse crisis. Clearly, there are disagreements as to the causes of the current crisis. However, there is far more agreement as to its enormity and many of the steps necessary to address it; in particular, approaching the current crisis through increasing the delivery of and access to harm reduction strategies, treatment options and education.

Even interviewees who were critical of the work of those in other domains noted that, when they met these colleagues in the many multiple stakeholder meetings that have been organized across Indiana, they were always impressed by the shared dedication of those they met. In short, there are no bad actors here, but rather hard-working public and private stakeholders, many of whom are working in silos (or in budding collaborations across disciplines) while coping with inadequate resources.

In addition to questions tailored to their domain-expertise, the team asked all interviewees some general and open-ended questions. For example, all interviewees were asked how the crisis presented to them and impacted their work. The team also asked how each interviewee would define “success” in combating the crisis.

The answers to these open-ended, incidental comments volunteered by interviewees in the course of answering detailed questions—in addition to the team’s concurrent literature reviews—were the basis for the following *general* findings:

1. **Role of Healthcare System.** In many respects, the substance abuse crisis is a function of deficiencies in the overall healthcare system, both nationally and in Indiana. These deficiencies frequently are highlighted by pandemics, syndemics, or natural disasters. For example, concerns about or problems with healthcare delivery were quite apparent in the aftermath of Hurricane Katrina and during the Ebola outbreak. Crises, of whatever nature, stress the healthcare system, illustrating and exacerbating its weaknesses.
 - a. The United States spends more on its healthcare than any other country yet receives less both in terms of the percentage of the population receiving care and the quality of the care provided.
 - b. The list of symptoms and causative factors is long and includes: access problems (particularly for the very poor and the poor), high and increasing costs (including insurance costs, prescription drug costs, and cost-shifting), substandard care coordination, a frequently incoherent healthcare delivery model involving multiple types of entities and financing or reimbursement models, and severe deficiencies in data management and sharing. In short, *fixing* crises, such as the substance abuse crisis, depends on far more complex reform of the healthcare system.
 - c. Absent that reform, and in the meantime, responses largely will attempt to mitigate symptoms, rather than many of the underlying causes.
2. **Broader Addiction Problem.** The opioid epidemic is an addiction crisis, but it is not the only one the nation or Indiana have faced or will face in the future. The opioid epidemic is somewhat distinctive because some of its causes (drug over-prescription and misleading promotion) can be identified and some actors demonized. Its death toll also appears disproportionately high given the number of persons with OUD. However, at root the opioid epidemic is part of an addiction

problem that stretches back over a century, with each “crisis” tending to recycle “supply-side and criminal-justice approaches” rather than “an expanded public health response.”²³ Until we solve the broader addiction problem, we will be treating somewhat varying symptoms, not root causes.

3. **Describing the Problem.** Interviewees were asked to describe how the current substance abuse crisis presented to them in their professional capacities. Responses from persons across multiple domains included words or phrases such as “overwhelming,” “extremely enormous,” “the worst public health crisis” experienced in a career, “epidemic,” “out of control,” and “impacting all walks of life.” Some interviewees volunteered additional analyses such as:
 - a. Prior public health crises have seemed manageable—the substance abuse crisis has so many different aspects that the infrastructure is unable to cope;
 - b. There is a need for substantial increases in coordination across domains and agencies and the ending of policy and implementation silos;
 - c. Solutions are going to require cross-disciplinary systems and coordination.
4. **Impact of Crisis on Indiana.** Indiana is not unique among states in the seriousness of its substance abuse crisis. It is not even unique among Midwestern states (e.g., accurate parallels are frequently drawn to the situation in Ohio). However, there are some contributing issues that make the crisis particularly acute for Indiana.
 - a. Although Indiana is somewhat-average on per capita healthcare spending and average on per capita filling of prescriptions at retail pharmacies,²⁴ the State is one of the unhealthier states, particularly with regard to health behaviors and health outcomes.²⁵ While improving, Indiana funding for public health remains in the bottom third of all states, and Indiana is rated in the bottom ten states for infant and adult mortality rates, obesity, and smoking.²⁶ Indiana is not one of the poorest states, yet 32% of Hoosiers are poor (<200% FPL).²⁷ Furthermore, Indiana ranks in the bottom third for education and forty-eighth in the country for quality of life.²⁸
 - b. The intergenerational impact of the substance abuse crisis is particularly hard felt in Indiana. The State has seen some of the nation’s largest increases in children being removed from their homes by child protective services due to family drug use. In 2016, more than 1 out of every 2 cases of children removed from their homes by the Indiana Department of Child Services was due to drug or alcohol use by a parent—a rate that rose more than 50 percent since 2013.²⁹
5. **Decentralization of Local Government.** Indiana has 92 counties and a considerably decentralized local government infrastructure, including local public health departments and coroners. Several interviewees commented that this decentralized model created impediments to effective public health interventions compared to statewide or regional interventions. There

²³ Herzberg et al, *Recurring Epidemics of Pharmaceutical Drug Abuse in America: Time for an All-Drug Strategy*. 106 Am. J. Public Health 408, 409 (2016), available at <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302982>.

²⁴ *State Health Facts*, KAISER FAMILY FOUNDATION, <https://www.kff.org/statedata/> (last visited Mar. 25, 2018).

²⁵ *America’s Health Rankings Annual Report* (2017) https://assets.americahealthrankings.org/app/uploads/ahrannual17_complete-121817.pdf.

²⁶ *About Indiana*, U.S. NEWS, <https://www.usnews.com/news/best-states/indiana> (last visited Mar. 25, 2018).

²⁷ KAISER FAMILY FOUNDATION, MEDICAID IN INDIANA, (2017), available at <http://files.kff.org/attachment/fact-sheet-medicare-state-IN>.

²⁸ *About Indiana*, U.S. NEWS, <https://www.usnews.com/news/best-states/indiana> (last visited Mar. 25, 2018).

²⁹ , INDIANA YOUTH INSTITUTE, 2018 KIDS COUNT DATA BOOK 16 (2018), available at <https://s3.amazonaws.com/iyyi-website/data-book/2018-Indiana-KIDS-COUNT-Data-Book.pdf?mtime=20180205073618>.

is at least some intuitive support for this opinion from news stories about Indiana counties either refusing to institute syringe exchange programs³⁰ or prematurely ending them.³¹ The termination of local syringe exchange programs is itself a product of an outlier characteristic in Indiana law, as most states with syringe exchanges do not subject their programs to as frequent reviews for reauthorization as Indiana.³²

6. **Healthcare Interventions.** As previously noted, the reasons why the substance abuse crisis is a wicked problem include the identification of multiple causes and the advocacy for multiple solutions, some of which are mutually inconsistent or exhibit ideological or political biases. Notwithstanding, our interviewees were almost unanimous in their assessment of the current situation:
- a. Interviewees displayed broad, pragmatic agreement; the substance abuse crisis in Indiana has evolved to the point that improvements in healthcare interventions are imperative.
 - b. Multiple interviewees said improving outcomes in response to the substance abuse crisis requires seeing these issues principally as health concerns. As such, most interviewees concentrated on barriers to intervention and intervention priorities. First, as multiple interviewees stated, given the availability of naloxone, “no one should die.” Second, those persons presenting with SUD typically should receive evidence-based medication-assisted treatment (MAT).

³⁰ Shari Rudavsky, *Why Marion County Doesn't Have A Needle Exchange*, INDY STAR (Dec. 17, 2017), <https://www.indystar.com/story/news/2017/12/17/why-marion-county-doesnt-have-needle-exchange/949707001/>.

³¹ Leigh Hedger, *2nd Indiana County Ends Needle Exchange*, INDY STAR (Oct. 23, 2017), <https://www.indystar.com/story/news/2017/10/23/2nd-indiana-county-ends-needle-exchange-one-official-citing-moral-concerns/787740001/>.

³² United States Centers for Disease Control and Prevention, *Laws Related to Syringe Exchange*, <https://www.cdc.gov/hepatitis/policy/SyringeExchange.htm> (last visited Mar. 29, 2018).

FINDINGS: SPECIFIC LAW AND POLICY INTERVENTIONS

The research team identified eight law and policy areas meriting more detailed analysis. These topics do not purport to be comprehensive in terms of a coordinated law and policy response to the substance abuse crisis. Rather, they represent the initial findings that the team has evaluated based on a variety of factors including: 1) the results from expert interviews, 2) actionable solutions (based on perceived political feasibility), and 3) resources available to study this issue, generated by other institutions or government agencies.

1. HARM REDUCTION

A. Background

Harm reduction refers to public health interventions that seek to minimize illness and injuries associated with drug use, rather than seeking to reduce the incidence of drug use.³³ Examples of harm reduction interventions include increased naloxone availability,³⁴ increased access to sterile syringes via syringe exchange programs,³⁵ and safe consumption sites.³⁶

For example, Indiana's naloxone access law was passed in 2015.³⁷ This law permits healthcare providers to prescribe an overdose intervention drug, i.e. naloxone, without having to examine the individual.³⁸ The law was expanded the following year; now the Indiana State Department of Health (ISDH) is required to issue a statewide standing order for naloxone.³⁹ Under this standing order, any entity can dispense or prescribe naloxone in accordance with the statutory requirements. The entity must register with ISDH and provide education and training to recipients of the drug.⁴⁰ Prescribers, dispensers, and others who lawfully administer naloxone are immune from civil liability.⁴¹ Naloxone is available at over 500 locations throughout the state, including pharmacies, addiction treatment centers, non-profit organizations, health departments, schools, and correction facilities.⁴² Additionally, Indiana law permits

³³ UNITED NATIONS OFFICE ON DRUGS AND CRIME, REDUCING THE HARM OF DRUG USE AND DEPENDENCE https://www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%204/1.VoID_Topic4_Harm_Reduction.pdf, (last visited Mar. 25, 2018) (citing, Costigan G, Crofts N, & Reid G., *The Manual for Reducing Drug Related Harm in Asia*. Melbourne: Centre for Harm Reduction, MacFarlane Burnet Centre for Medical Research and Asian Harm Reduction Network (2003)).

³⁴ Daniel Kim, Kevin S. Irwin, & Kaveh Khoshnood, *Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality*, 99 AM. J. PUBLIC HEALTH 402, 405 (2009), available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2008.136937>.

³⁵ Don C. Des Jarlais et al., *Doing Harm Reduction Better: Syringe Exchange in the United States*, 104 ADDICTION 1141 (2009), available at <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1360-0443.2008.02465.x>.

³⁶ Tim Rhodes et al., *Public Injecting And The Need for 'Safe Environment Interventions' in The Reduction of Drug-Related Harm*, 101 ADDICTION 1384 (2006), available at <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1360-0443.2006.01556.x>.

³⁷ Pub.L. No. 32-2015 (codified as amended at Ind. Code 16-42-27-2 (2018)).

³⁸ Pub.L. No. 32-2015 (codified as amended at Ind. Code 16-42-27-2 (2018)).

³⁹ IND. CODE 16-42-27-2(f) (2018); see also *State Health Commissioner Renews Naloxone Standing Order*, INDIANA STATE DEPARTMENT OF HEALTH (June 2017), http://www.in.gov/activecalendar/EventList.aspx?view=EventDetails&eventidn=265808&information_id=270184&type=syndicate=syndicate.

⁴⁰ IND. CODE 16-42-27-2(a), (e) (2018).

⁴¹ IND. CODE 16-42-27-3 (2018).

⁴² *Indiana Health Commissioner Extends Naloxone Availability*, WANE.COM (June 30, 2017, 3:47 PM), <http://wane.com/2017/06/30/indiana-health-commissioner-extends-naloxone-availability/>; *Save A Life: Help Prevent Overdose Deaths*, INDIANA STATE DEPT. OF HEALTH, <https://optin.in.gov/> (last visited Mar. 25, 2018).

schools to stock naloxone.⁴³ However, the Indy Star reported in 2017 that many schools are hesitant to stock the drug and instead rely on school officers or emergency services.⁴⁴

Indiana law also permits local governments to operate syringe exchange programs (SEPs)⁴⁵ in the event of “an epidemic of hepatitis C or HIV” when “the primary mode of transmission of hepatitis C or HIV in the county is through intravenous drug use.”⁴⁶ The law requires SEPs to register with the state health department, have a healthcare provider oversee the program, and provide participants with information about addiction treatment, among other requirements.⁴⁷ Several localities are currently operating SEPs, including Monroe County and Allen County.⁴⁸

While Indiana law does not authorize safe consumption sites, several jurisdictions outside of Indiana have implemented this harm reduction strategy, the first of its kind in the United States.⁴⁹ Safe consumption sites are locations in which persons with SUD can consume drugs in an environment monitored by healthcare providers. This strategy minimizes injury and promotes overdose prevention.⁵⁰ Some evidence suggests these sites reduce the number of overdoses and can link individuals to addiction treatment opportunities.⁵¹

B. Findings

As outlined above, Indiana has incorporated several evidence-based harm reductions strategies into state law. However, additional opportunities exist to further promote such strategies to address the addictions crisis in regard to overdose immunity laws, drug paraphernalia laws, and safe stations.

⁴³ IND. CODE 20-34-4.5 (2018).

⁴⁴ Emma Kate Fittes, *Indiana Schools Can Stock Naloxone, But Will They?*, INDYSTAR (Nov. 8, 2017, 9:52 AM), <https://www.indystar.com/story/news/local/2017/11/08/why-some-indiana-schools-should-indiana-schools-stock-overdose-reversing-drug-naloxone-why-some-say-the/585595001/>.

⁴⁵ IND. CODE 16-41-7.5-1 et seq. (2018).

⁴⁶ IND. CODE 16-41-7.5-5(1) (2018).

⁴⁷ IND. CODE 16-41-7.5-6 (2018).

⁴⁸ *Syringe Exchange Program*, Monroe County Indiana, www.co.monroe.in.us/tsd/Community/HealthDepartment/SyringeExchangeProgram.aspx (last visited Mar. 25, 2018); *Syringe Services Program*, THE FORT WAYNE-ALLEN COUNTY DEPT. OF HEALTH, <http://www.allencountyhealth.com/get-informed/ssp/> (last visited Mar. 25, 2018).

⁴⁹ *Let Cities Open Safe Injection Sites*, THE NEW YORK TIMES (Feb. 24, 2018), <https://www.nytimes.com/2018/02/24/opinion/sunday/drugs-safe-injection-sites.html>; *Seattle Budget Includes Money for Safe-Injection Site*, KIRO (Nov. 21, 2017, 9:40 AM), <https://www.kiro7.com/news/local/seattle-budget-includes-money-for-safe-injection/651500019>; Heather Knight, *SF Safe Injection Sites Expected to be First in Nation, Open Around July 1*, SAN FRANCISCO CHRONICLE (Feb. 5, 2018, 8:26 AM), <https://www.sfchronicle.com/news/article/SF-safe-injection-sites-expected-to-be-first-in-12553616.php>; https://www.nytimes.com/2018/02/20/opinion/philadelphia-opioid-overdose-treatment.html?rref=collection%2Fcolumn%2Ffixes&action=click&contentCollection=opinion®ion=stream&module=stream_unit&version=latest&contentPlacement=1&pgtype=collection; See also, Leo Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in The United States*, 98 Am. J. Public Health 231 (2008), available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2006.103747>.

⁵⁰ Leo Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in The United States*, 98 Am. J. Public Health 231 (2008), available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2006.103747>.

⁵¹ Brandon DL Marshall et al., *Reduction in Overdose Mortality After The Opening of North America’s First Medically Supervised Safer Injecting Facility*, 377 THE LANCET 1429 (2011), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)62353-7/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62353-7/abstract); Jennifer Ng, Christy Sutherland, & Michael R. Kolber, *Does Evidence Support Supervised Injection Sites?*, 63 CAN FAM PHYSICIAN 866 (2017), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5685449/>; Leo Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in The United States*, 98 Am. J. Public Health 231 (2008), available at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2006.103747>.

1. Overdose Immunity Laws

For friends and family members of an individual experiencing an overdose situation, fear of criminal liability, for themselves and the individual overdosing, is the primary factor deterring them from seeking emergency services.⁵² Overdose Immunity Laws, also known as 911 Immunity Laws and Good Samaritan Laws, seek to reduce preventable overdose deaths by providing immunity from criminal prosecution to bystanders and, in some jurisdictions, to individuals experiencing an overdose situation, thus eliminating the primary reason for failing to seek emergency care.⁵³

Indiana's overdose immunity law was enacted in 2016⁵⁴ and provides criminal immunity for drug possession and drug paraphernalia charges to individuals that seek emergency medical assistance to aid someone in an overdose situation.⁵⁵ To be eligible for immunity, an individual must meet the following requirements:

1. Legally obtained an overdose intervention drug;⁵⁶
2. Administered an overdose intervention drug;⁵⁷
3. Provided the full name of individual experiencing an overdose and any relevant information requested by law enforcement;⁵⁸
4. Remained at the scene with the individual overdosing until emergency services arrived;⁵⁹
5. Cooperated with emergency personnel and law enforcement;⁶⁰
6. Encountered law enforcement when seeking to assist an individual experience an overdose.⁶¹

Uniquely, Indiana is the only state in the country that links immunity to the administration of overdose intervention drugs.⁶² However, bystanders and individuals experiencing an overdose can be afforded a mitigated sentence if they were convicted of a drug-related crime, which was facilitated due to requesting emergency services.⁶³ Multiple interviewees recommended that overdose immunity

⁵² See, *Preventing the Consequences of Opioid Overdose: Understanding 911 Good Samaritan Laws*, SAMHSA's CENTER FOR THE APPLICATION OF PREVENTION TECHNOLOGIES (November 8, 2017), available at <https://iu.app.box.com/file/267744244520>; Zach Myers, *Police Urge People to Call 911 to Report Overdoses Despite Risk of Arrest*, Fox 59 (May 15, 2017), <http://fox59.com/2017/05/15/police-urge-911-calls-for-overdoses-despite-risk-of-arrest/>; K. Tobin, et al., *Calling Emergency Medical Services during Drug Overdose: An Examination of Individual, Social and Setting Correlates*, 100 ADDICTION 397, 398 (2005).

⁵³ SAMHSA's CENTER FOR THE APPLICATION OF PREVENTION TECHNOLOGIES, PREVENTING THE CONSEQUENCES OF OPIOID OVERDOSE: UNDERSTANDING 911 GOOD SAMARITAN LAWS (2017), available at <https://www.samhsa.gov/capt/sites/default/files/resources/good-samaritan-law-tool.pdf>.

⁵⁴ 2016 Ind. Legis. Serv. P.L. 6-2016 (S.E.A. 187).

⁵⁵ IND. CODE § 16-42-27-2(g), (h) (2018).

⁵⁶ IND. CODE § 16-42-27-2(g)(1), (2) (2018).

⁵⁷ IND. CODE § 16-42-27-2(g)(3) (2018).

⁵⁸ IND. CODE § 16-42-27-2(g)(4) (2018).

⁵⁹ IND. CODE § 16-42-27-2(g)(5) (2018).

⁶⁰ IND. CODE § 16-42-27-2(g)(5) (2018).

⁶¹ IND. CODE § 16-42-27-2(g)(6) (2018).

⁶² See, *Drug Overdose Immunity and Good Samaritan Laws*, NATIONAL CONFERENCE OF STATE LEGISLATURES (Jun. 5, 2017), http://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx#Calling_911; see also, Legal Science, *Good Samaritan Overdose Prevention Laws*, PRESCRIPTION DRUG ABUSE POLICY SYSTEM, <http://pdaps.org/datasets/good-samaritan-overdose-laws-1501695153> (last updated Dec. 1, 2016).

⁶³ IND. CODE § 35-38-1-7.1(b)(12) (2018).

protections be expanded under Indiana law. Evidence indicates that overdose immunity laws correlate to lower rates of opioid-overdose mortality.⁶⁴

Legislative efforts to expand access to overdose intervention drugs in Indiana are relatively recent. Research has yet to indicate that the average bystander in an overdose situation will have naloxone on hand. Thus, linking immunity in a drug overdose situation severely limits the number of applicable overdose situations and does not eliminate the fear of criminal liability for individuals present during the overdose situation.

Indiana's immunity does not extend to the individual who is in need of medical assistance. Reports suggest bystanders are often reluctant to seek emergency services for individuals in the overdose situation for fear of not only their own criminal liability but also the criminal liability of those experiencing the overdose.⁶⁵ Several states, including New Mexico and Washington, have enacted broader drug overdose immunity laws to provide protections to both bystanders and the individual in an overdose situation.⁶⁶

While Indiana's immunity includes protections from drug possession and drug paraphernalia charges,⁶⁷ it does not extend to parole or probation violations, alcohol related offenses, or to the execution of warrants. One interviewee indicated that, even if law enforcement officers choose not to arrest someone for possessing drug paraphernalia, officers would be obligated to follow-up if there was an outstanding warrant against that person.

2. Drug Paraphernalia Laws

Indiana law makes it unlawful to possess drug paraphernalia, instruments, devices, or other objects intended for introducing, testing, or enhancing a controlled substance.⁶⁸ It also prohibits providing another individual with drug paraphernalia.⁶⁹ Syringes used to inject an illegal drug can be considered drug paraphernalia under Indiana law.⁷⁰ Violation of the drug paraphernalia law is considered a misdemeanor.⁷¹ However, Indiana law elevates the offense to a felony if the paraphernalia is a syringe or needle.⁷² Individuals distributing syringes as part of a syringe exchange program are exempt from criminal liability under Indiana's distribution of drug paraphernalia⁷³ as are bystanders possessing drug

⁶⁴ See, e.g., Chandler McClellan et. al, Opioid-overdose laws association with opioid use and overdose mortality, *Addictive Behaviors*, (forthcoming 2018); Corey Davis, Damika Webb, & Scott Burris, *Changing Law From Barrier to Facilitator of Opioid Overdose Prevention*, 41 J. LAW MED ETHICS 33 (2013).

⁶⁵ *Preventing the Consequences of Opioid Overdose: Understanding 911 Good Samaritan Laws*, SAMHSA'S CENTER FOR THE APPLICATION OF PREVENTION TECHNOLOGIES (November 8, 2017), available at <https://iu.app.box.com/file/267744244520>.

⁶⁶ See, e.g., N. M. Stat. Ann. § 30-31-27.1 (2018); WASH. REV. CODE ANN. § 69.50.315 (2018).

⁶⁷ IND. CODE § 16-42-27-2(h) (2018).

⁶⁸ IND. CODE § 35-48-4-8.3(b) (2018).

⁶⁹ IND. CODE § 35-48-4-8.5 (2018).

⁷⁰ See, e.g., Perkins v. State, 57 N.E.3d 861 (Ind. Ct. App. 2016); Sluder v. State, 997 N.E.2d 1178 (Ind. Ct. App. 2013); Moore v. State, 223 N.E.2d 899 (Ind. 1976). See, also, Cooper v. State, 357 N.E.2d 260 (Ind. Ct. App. 1976) (stating that the drug paraphernalia can be based on the intent of use).

⁷¹ IND. CODE § 35-48-4-8.3(b) (2018).

⁷² IND. CODE § 16-42-19-18 (2018).

⁷³ IND. CODE § 35-48-4-8.5(c)(3), (4) (2018).

paraphernalia during an overdose emergency under Indiana’s overdose immunity law described above.⁷⁴

Several interviewees identified Indiana’s drug paraphernalia law as a legal barrier to an effective response in the substance use crisis. One interviewee in law enforcement indicated that criminal liability under such laws served as leverage to encourage persons with SUD to seek treatment or participate in drug court. However, another interviewee disputed this notion stating that this approach “hasn’t fixed [the SUD crisis].”

Following the devastating HIV outbreak in southern Indiana due to sharing unsterile syringes for drug use, Indiana law now permits local governments to operate syringe exchange programs (SEPs).⁷⁵ Evidence strongly suggests that SEPs are an effective way to reduce disease transmission,⁷⁶ link those with SUD to treatment and other services,⁷⁷ and can be less costly than providing healthcare services for preventable diseases.⁷⁸ While individuals distributing syringes through a SEP are exempt from criminal liability,⁷⁹ those securing syringes from a SEP are not exempt from criminal liability under Indiana’s drug paraphernalia law. Conversely, North Carolina law allows for limited immunity for drug paraphernalia “if the person claiming immunity provides written verification that a needle, syringe, or other injection supplies were obtained from a needle and hypodermic syringe exchange program.”⁸⁰ Drug paraphernalia laws that do not provide immunity to those securing syringes via SEPs can limit the efficacy of SEPs. One expert indicated that part of SEP success is based on a participant’s ability to feel safe while at the program, which might include safety from criminal prosecution.

Multiple interviewees highlighted the discretion law enforcement possess regarding whether to arrest or charge individuals for possession of drug paraphernalia when they possess a syringe. One interviewee indicated that they generally prefer not to arrest individuals in such instances; however, this interviewee acknowledged that, in the field, law enforcement officers may also exercise their discretion to arrest someone for this crime.

3. Safe Stations

Safe Stations are an alternative strategy that some jurisdictions have implemented to link persons with SUD to care.⁸¹ For example, the Michigan State Police Department (MSP) has established an “Angel

⁷⁴ IND. CODE § 16-42-27-2(g), (h) (2018).

⁷⁵ IND. CODE 16-41-7.5-1 et seq. (2018).

⁷⁶ See, e.g., Philip J. Peters, et. al., *HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014-2015*, 375 NEW ENG. J. MED. 229, 237 (2016); Steffanie A. Strathdee & Chris Beyrer, *Threading the Needle – How to Stop the HIV Outbreak in Rural Indiana*, 373 NEW ENG. J. MED. 397, 398 (2015); Effectiveness of Sterile Needle And Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users, WORLD HEALTH ORGANIZATION (2014), available at www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf?ua=1; Don C. Des Jarlais et al., *HIV Incidence Among Injecting Drug Users in New York City Syringe-Exchange Programmes*, 348 Lancet 987 (2016), available at <https://www.ncbi.nlm.nih.gov/pubmed/8855855>; Holly Hagan et al., *Reduced Risk of Hepatitis B and Hepatitis C Among Injection Drug Users in The Tacoma Syringe Exchange Program*, 85 Am. J. Public Health 1531 (1995), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615682/>.

⁷⁷ S. A. Strathdee, et al., *Needle-Exchange Attendance And Health Care Utilization Promote Entry Into Detoxification*, 76 J. URBAN HEALTH 448 (1999), available at <https://www.ncbi.nlm.nih.gov/pubmed/10609594>.

⁷⁸ T. Q. Nguyen, et al., *Syringe Exchange in The United States: A National Level Economic Evaluation of Hypothetical Increases in Investment*, 18 AIDS BEHAV 2144 (2014), available at <https://www.ncbi.nlm.nih.gov/pubmed/24824043>.

⁷⁹ IND. CODE § 35-48-4-8.5(c)(3), (4) (2018).

⁸⁰ N.C. GEN. STAT. ANN. § 90-113.27 (2018).

⁸¹ ‘Safe Stations’ Program Offers Path to Recovery for Opioid, Heroin Addicts, COUNTY NEWS (Sep. 18, 2017), www.naco.org/articles/'safe-stations'-program-offers-path-recovery-opioid-heroin-addicts.

Program” in which individuals who seek addiction treatment can receive information and transportation to a treatment facility at any MSP post during business hours.⁸² Further, in East Manchester, New Hampshire, fire stations provide similar services twenty-four hours a day.⁸³ To be eligible to participate, an individual must be eighteen years or older, regardless of whether they have health insurance or not.⁸⁴ The city of East Manchester has experienced a drop in the number of overdoses since implementing the program.⁸⁵ Additionally, the treatment facilities affiliated with the “Safe Station” program have reported that, of the more than one-thousand participants entering and exiting the program, 70 percent complete their treatment.⁸⁶ One interviewee indicated that a safe stations might be an effective intervention in Indiana.

C. Opportunities

Based on the success of safe stations in other jurisdictions, Indiana entities should consider:

- Repealing the requirement that bystander immunity be linked to the administration of overdose intervention drugs;
- Extending immunity to include the individual needing medical assistance;
- Extending immunity to include violations such as execution of warrants, parole/probation violations, and alcohol-related offenses;
- Providing immunity to individuals possessing syringes secured from syringe exchanging programs;
- Granting immunity to overdose victims for possession of drug paraphernalia; and
- Implementing safe station programs.

⁸² Michigan State Police, *MSP Angel Program*, http://www.michigan.gov/msp/0,4643,7-123-72297_34040_77095-394452--,00.html (last visited Mar. 25, 2018).

⁸³ Manchester Fire Department, *Safe Station*, <https://www.manchesternh.gov/Departments/Fire/Safe-Station> (last visited Mar. 25, 2018).

⁸⁴ *Spotlight: Manchester, NH Fire Department Safe Stations Program* (April 2017), http://docs.wixstatic.com/ugd/bfe1ed_c2015ef58460406aa0dd166ece461f7e.pdf.

⁸⁵ *Spotlight: Manchester, NH Fire Department Safe Stations Program* (April 2017), http://docs.wixstatic.com/ugd/bfe1ed_c2015ef58460406aa0dd166ece461f7e.pdf.

⁸⁶ *Spotlight: Manchester, NH Fire Department Safe Stations Program* (April 2017), http://docs.wixstatic.com/ugd/bfe1ed_c2015ef58460406aa0dd166ece461f7e.pdf.

2. HEALTHCARE INTERVENTIONS

A. Background

Prior reports, including The Surgeon-General's Report (2016),⁸⁷ multiple interviewees from different domains, and our original research identified multiple and varied public health and healthcare delivery interventions to prevent or alleviate the consequences of SUD. In this section, we identify appropriate interventions and/or barriers to interventions.

B. Findings

Indiana policymakers have made several positive changes to health Interventions in Indiana. These include:

- The Indiana State Department of Health (ISDH) has increased the availability of naloxone and removed barriers such as pre-authorization.⁸⁸
- The Indiana Family and Social Services Administration (FSSA) has successfully applied for an extension to the State's Section 1115 Medicaid demonstration program, extending Medicaid coverage to those suffering from SUD for short-term residential stays in Institutions for Mental Diseases.⁸⁹ Indiana's Medicaid program now also reimburses all three evidence-based drug treatments.
- The State has opened⁹⁰ or authorized the opening⁹¹ of additional treatment facilities.
- There are ongoing initiatives led by the Chief Justice of the Indiana Supreme Court and her Office of Judicial Administration to train judges, prosecutors, public defenders, and probation officers in the evidence-base for Medication Assisted Treatment (MAT).
- Improvements have been made regarding the availability of information about available inpatient treatment facilities through a partnership between *Open Beds*, FSSA, and Indiana 2-1-1.⁹²

However, real or perceived barriers to effective interventions remain. Our interviewees and original research addressed the following policy issues and legal barriers:

1. Syringe exchange program

Earlier in this preliminary report, we present some detailed findings on harm reduction strategies, including legal barriers to the effective leveraging of syringe exchange programs and the relatively

⁸⁷ *Early Intervention, Treatment, and Management of Substance Use Disorders*, in Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, And Health, 4-1 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

⁸⁸ *Save A Life: Help Prevent Overdose Deaths*, INDIANA STATE DEPT. OF HEALTH, <https://optin.in.gov/> (last visited Mar. 30, 2018).

⁸⁹ CMS Approval Letter to FSSA (Feb. 1, 2018), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>.

⁹⁰ Scott L. Miley, *Governor Announces Five More Opioid Treatment Programs in Indiana*, THE HERALD BULLETIN.COM (Jul. 5, 2017), http://www.heraldbulletin.com/news/state_news/governor-announces-five-more-opioid-treatment-programs-in-indiana/article_2edb9758-619d-11e7-b2b0-cbd8274307ef.html.

⁹¹ House Enrolled Act 1007 (2018), available at <https://iga.in.gov/legislative/2018/bills/house/1007#document-273dbd52>.

⁹² *Indiana Announces New Partnership to Connect Hoosiers with Drug Treatment*, FSSA NEWS RELEASE (Mar. 15, 2015), available at <http://www.in.gov/fssa/files/FINAL-OpenBeds-211-press-release.pdf>.

narrow application of Indiana's limited "Good Samaritan" safe harbor. Here, we examine harm reduction more generally in the context of the healthcare continuum of care.

The State's syringe exchange program (SEP) remains incoherent with major county-by-county variations. This is despite the clear evidence base for exchanges as recognized by, for example, the Surgeon-General's Report (2016),⁹³ their proven role in reducing the transmission of HIV/AIDS⁹⁴ and overall cost-effectiveness.⁹⁵ Some of these variations may be reduced if the state increases education designed to reduce stigma and emphasize the medical pathology of SUD.

There is strong evidence SEPs open a path to treatment and do not increase rates of addiction.⁹⁶ Implementation of syringe exchange programs also have been found to reduce the risk of needle stick injuries among law enforcement officers in the community.⁹⁷ In addition, SEPs are safe places and a place of re-entry from the streets for those with SUD. One of our interviewees described SEPs as places where persons with SUD "get love for the first time in a long time... [someone says] I don't want you to die!" From another interviewee, we learned of a white board in one SEP that simply read, "You Are Loved."

Policymakers should recognize the far broader role of syringe exchanges. In practice, syringe exchange programs are modest, but critically important healthcare facilities. They offer persons with SUD route to a safer life, the minimization of comorbidities such as HIV/AIDS or Hepatitis-C, treatment, and even recovery.⁹⁸ They not only provide clean syringes and other preventive equipment, they also are a source of naloxone, HI/AIDS and Hepatitis-C testing, and information about Medicaid eligibility. Some SEP staff are health professionals, many others are "certified navigators." However, although they account for so many primary interventions, syringe exchanges are barely integrated into the continuum of care. Neither is the knowledge base collected by the exchanges leveraged by policymakers.

Although some stakeholders have endorsed trying Supervised (or Safer) Injection Facilities (SIFs),⁹⁹ they remain highly controversial even in states that do not share Indiana's historical and cultural values. However, there are far less controversial, intermediate programs, creating *safe* spaces additional to syringe exchanges where persons with SUD or concerned family members know they can find naloxone and a connection to treatment.¹⁰⁰ Recognizing exchanges and other safe spaces as critical components of the SUD continuum of care and linking them to effective treatment resources seems to be overdue.

⁹³ *Early Intervention, Treatment, and Management of Substance Use Disorders*, in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, 4-1, 4-10 to 11 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

⁹⁴ Don C. Des Jarlais, et al., *HIV Incidence Among Injecting Drug Users in New York City Syringe-Exchange Programmes*, 348 THE LANCET 987 (1996), available at <https://www.sciencedirect.com/science/article/pii/S0140673696025366>.

⁹⁵ T. Q. Nguyen, et al., *Syringe Exchange in The United States: A National Level Economic Evaluation of Hypothetical Increases in Investment*, 18 AIDS BEHAV. 2144 (2014), available at <https://www.ncbi.nlm.nih.gov/pubmed/24824043>.

⁹⁶ Steffanie A. Strathdee et al., *Needle-Exchange Attendance And Health Care Utilization Promote Entry into Detoxification*, 76 J. URBAN HEALTH 448 (1999), available at <https://www.ncbi.nlm.nih.gov/pubmed/10609594>.

⁹⁷ Samule L. Groseclose et al., *Impact of Increased Legal Access to Needles And Syringes on Practices of Injecting-Drug Users And Police Officers--Connecticut, 1992-1993*, 10 J. Acquir. Immune. Defic. Syndr. Hum. Retrovirol 82 (1995).

⁹⁸ SYRINGE EXCHANGE PROGRAMS, AIDS WATCH (2015), available at https://www.aidsunited.org/data/files/Site_18/AW2015-SyringeExchange_Web.pdf.

⁹⁹ Martha Bebinger, *AMA Endorses Trying Supervised Injection Facilities*, WBUR (June 16, 2017), <http://www.wbur.org/commonhealth/2017/06/16/ama-supervised-injection-facilities-opioids>.

¹⁰⁰ See e.g., Manchester, New Hampshire Safe Stations program discussed in the Harm Reduction section of this report.

2. Tertiary Interventions

The typical tertiary interventions take place at Emergency Departments (EDs), with patients being delivered by EMS or law enforcement. One of our healthcare provider interviewees estimated that 40-60% of those presenting at Emergency Departments with SUD had comorbidities, in particular mental health illnesses. Additionally, the criminal justice system is responsible for the initiation of tertiary interventions when, for example, judges make dispositions subject to treatment. For those arrested or convicted, jails or correctional facilities may be the site of tertiary interventions. Our interviewees and original research identified several issues that create barriers to effective interventions.

A. Judicially-Ordered Interventions

From both our interviewees and original research, we found there was still a major barrier to effective tertiary interventions--the lack of consensus around MAT as the evidence-based treatment of choice. One interviewee went further, expressing the opinion that increasingly, treatment options have been taken out of the hands of healthcare providers and given to judges. This is part of a national failure to provide a full range of evidence-based treatments to persons involved in the justice system.¹⁰¹

Interviewees also were concerned about judicial tendencies in some Indiana courts to prefer unproven strategies and the relatively narrow range of treatments recommended from the bench. Concern also was voiced about what was seen as the growing influence of device and drug detailers on the judiciary.

B. Availability and Quality within the Criminal Justice System

Jails: Many of our interviewees expressed concern with the quantity and quality of treatment provided within the criminal justice system. One interviewee commented, “Anything is better than [what is provided in] jail!” A member of law enforcement informed us, “People don’t get help in jail.” Another told us, “The jail doesn’t have the capacity to fully address these individuals’ needs.” This problem has been exacerbated by a large increase in the number of persons with SUD being held in jails (some for extended periods of time) and we were told persons in jail on a “pretrial hold” “cannot get treatment at all.” The same interviewee explained, although some judges make their orders dependent upon the defendant undergoing treatment, these orders typically are made at the end of the case, by which time it may be too late.

Department of Correction: Healthcare services provided to persons in Department of Correction (DoC) facilities have had something of a checkered history. For example, in 2016 the Department settled a long-standing class action lawsuit regarding the segregated confinement of seriously mentally ill prisoners, promising them “minimum adequate treatment.”¹⁰² Over the past two years, DoC has made significant changes to its intake screening protocols and adopted a new assessment tool for persons with SUD. This has been accompanied by changes in treatment protocols increasing the availability of

¹⁰¹ Noa Krawczyk et al., Only One in Twenty Justice-Referred Adults In Specialty Treatment For Opioid Use Receive Methadone Or Buprenorphine, 36 Health Aff. 2046 (2017), available at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0890>.

¹⁰² ACLU of Indiana, Indiana Protection & Advocacy Services Announce Settlement with Department of Correction (Jan. 27, 2016), available at <https://www.aclu.org/news/aclu-indiana-indiana-protection-advocacy-services-announce-settlement-department-correction>.

naltrexone and extended services.¹⁰³ The new pre-release protocol is a 30-day course of naltrexone followed by a single-injection of its extended-release form (Vivitrol). The current DoC contract with its healthcare provider does not include broader, wrap-around services such as outpatient services at release. The current “state-of-the art” model for corrections-based treatment is Rhode Island. There, the Department of Corrections offers a full range of MAT to everyone in its prison system. Rhode Island has a far smaller prison population than Indiana and has an integrated jail-prison system in a single location.¹⁰⁴ Notwithstanding it presents an integrated model worthy of study.

Interviewees from provider and state agency domains noted a disconnect between DoC and managed care entities (MCEs) at release. Case managers work with persons about to be released to provide them with identification and other documentation and send a spreadsheet to the Division of Family Resources (DFR) to trigger a change in Medicaid status from “suspended” to “active.” Sometimes, that activation does not occur. Another issue identified is while the MCEs are notified of the identities of their reactivated patients, it can take considerably longer for their records or other information noting SUD to reach the MCEs so they can institute wraparound and treatment services during a critical time.

We were told that there would be multiple benefits if a person’s Medicaid coverage was reactivated 30 days prior to release. Information-sharing would improve and community care providers would be incentivized to make the transition smoother, while providing wraparound and treatment services. In 2016, New York made a Section 1115 waiver request to institute such a program to pay for essential coordination and services prior to release.¹⁰⁵ However, the proposal was dropped after the 2016 election.

3. Access to/Cost of Treatment

SUD-related healthcare interventions are costly. The access of persons with SUD to treatment is, as with other healthcare services, a function of their insurance coverage.

Private Health Insurance: As a consequence of the *Affordable Care Act* (ACA) (2010), individual health insurance policies offered on the exchanges must cover behavioral health treatment, mental and behavioral health inpatient services, and SUD treatment.¹⁰⁶ Further, under the *Mental Health Parity and Addiction Equity Act* (2008), as amended by the ACA, individual, group health, and Medicaid managed care plans, must offer parity in their provision of mental health/substance use disorder benefits and medical/ surgical benefits.

As a result, those with private insurance have reduced barriers to treatment. However, it is not unlimited, being subject to co-pays and “treatment days/stays” limitations. “Typical” private health insurance barriers also can arise, for example a treatment facility may be “out of network.” One

¹⁰³ Alexis Dean & Stephanie Spoolstra, *Addressing Addiction behind the Walls*, Indiana Department of Correction (2016), available at <https://www.in.gov/bitterpill/files/Addressing%20Addiction%20Behind%20The%20Walls%20-%20Spoolstra%20and%20Dean.pdf>.

¹⁰⁴ Andrew Joseph, *One State Takes A Novel Approach to Opioid Addiction: Access to Treatment for All Inmates*, STAT NEWS (Aug. 3, 2017), available at <https://www.statnews.com/2017/08/03/opioid-treatment-prisons/>.

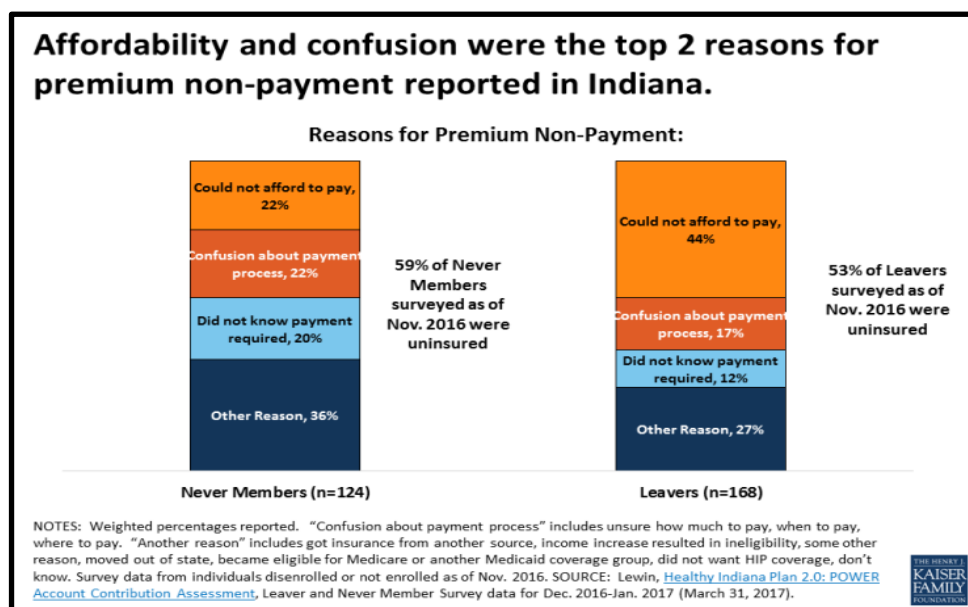
¹⁰⁵ Governor Cuomo Marks National Re-Entry Week By Seeking to Expand Medical Coverage For Individuals Leaving Incarceration (Apr. 29, 2016), available at <https://www.governor.ny.gov/news/governor-cuomo-marks-national-re-entry-week-seeking-expand-medical-coverage-individuals-leaving>.

¹⁰⁶ For current benefits see Indiana 2017 EHB Benchmark Plan Information at M-13, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/IN-BMP.zip>.

interviewee told us that when he arrived at a facility to arrange treatment for a family member, he was asked for a five-figure sum in advance.

Medicaid/HIP: The Indiana Medicaid population is approximately 1.4 million.¹⁰⁷ A state government interviewee estimated that 100,000 (or 7%) suffered from SUD but volunteered that under-reporting made it likely that the number was roughly twice that (or 14%). Interviewees and our research suggest that aspects of the Indiana HIP program and its extension will have a disproportionately negative impact on those with SUD.

Since 2015, Indiana's Medicaid program has been working as a demonstration under a federally-granted Section 1115 waiver. Under the original waiver, Medicaid benefits were tiered; only the higher tier



included vision and dental coverage and did not impose a co-pay for most services. To qualify for the higher tier, otherwise eligible persons had to contribute to a health savings account. In broad terms, failure to do so would move those at 100% Federal Poverty Level (FPL) or below to the lower benefits tier, while those above 100% FPL would not receive benefits, or if they stopped paying would be locked out of benefits for a period of time.

One of our interviewees noted that this original version of HIP "leads with paperwork not treatment" and many patients with SUD and/or those with mental health comorbidities were unable to handle the monetary or administrative burdens associated with establishing HIP eligibility. Recently published research supports such a conclusion; 55% of those eligible to pay premiums (some 287,000 persons) failed to do so, either dropping down to the lower benefits tier (< 101% FPL) or never being enrolled or

¹⁰⁷ Kaiser Family Foundation, *Medicaid in Indiana* (June 2017), <http://files.kff.org/attachment/fact-sheet-medicaid-state-IN>.

losing coverage (>100% FPL).¹⁰⁸ “The top two reasons cited by people who never enrolled in or lost HIP 2.0 coverage were affordability and confusion about the payment process.”¹⁰⁹

The 2018 extension to the Indiana Medicaid program includes additional potential barriers to Medicaid enrollment. For example, the extension approves a tobacco surcharge, a work requirement (beginning in 2019), and more process requirements.¹¹⁰ Persons with SUD and co-morbidities such as mental illness will have difficulty meeting the accompanying administrative requirements. Frequently they are transients whose qualifying paperwork fails to reach them. Many fall in and out of relapse making regular employment problematic. The new program will be subject to the Americans with Disabilities Act, contains a SUD-exception from the work requirement, and a medical frailty care exception to lockout. However, it is unclear how these will operate and how substantiation burdens will fall on those with SUD. It is at least arguable these additional requirements will increase the barriers to healthcare among the poor and very poor in Indiana, and disproportionately impact persons with SUD and comorbidities such as mental health illnesses.¹¹¹

Uninsured Persons: We were told by multiple interviewees that for the many who could not afford treatment or were not covered by Medicaid or private health insurance, there were few options. For example, the only option in Marion County was the Salvation Army *Harbor Light* detoxification facility.¹¹² This seems particularly to be the case for persons with SUD re-entering society from DoC.

4. Availability of Treatment

Multiple interviewees noted a critical lack of treatment programs and facilities in Indiana. For example, one interviewee told us the only treatment facility in Marion County is working far over-capacity. Another interviewee told us this facility has a waiting list and generally lamented the lack of inpatient and outpatient treatment opportunities. Another interviewee who works with a large SUD population in another county simply said, “there is nowhere to send them,” noting 2-3 month waiting lists, and that most available programs were abstinence-only, remarking that such programs had very poor results.

5. Post-Treatment Services

Some of our interviewees mentioned the importance of post-treatment services to keeping persons with SUD from relapsing. However, we found little evidence that Indiana was making progress in the provision of interventions designed to support those in recovery and/or in re-entry from correctional

¹⁰⁸ Robin Rudowitz, MaryBeth Musumeci & Elizabeth Hinton, *Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums*, KAISER FAMILY FOUNDATION (March 2018), <http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums>.

¹⁰⁹ Robin Rudowitz, MaryBeth Musumeci & Elizabeth Hinton, *Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums*, KAISER FAMILY FOUNDATION, at 4 (March 2018), <http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums>.

¹¹⁰ MaryBeth Musumeci, Robin Rudowitz, and Elizabeth Hinton, *Approved Changes in Indiana's Section 1115 Medicaid Waiver Extension*, KAISER FAMILY FOUNDATION (Feb. 09, 2018), <https://www.kff.org/medicaid/issue-brief/approved-changes-in-indianas-section-1115-medicare-waiver-extension/>.

¹¹¹ Hannah Katch et al., *Medicaid Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes*, Center on Budget and Policy Priorities (Feb. 8, 2018), <https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen>.

¹¹² *Detox Treatment*, THE SALVATION ARMY HARBOR LIGHT, <http://corps.salvationarmyindiana.org/harborlight/detox/> (last visited Mar 26, 2018).

facilities. Rather, we were told of stigma and legal or practical barriers to accessing necessities such as housing and employment.

Several interviewees discussed the lack of sober, safe, or supportive living environments. Indeed, overall there is a dearth of wrap-around services, recovery support services, and counselling. As is the case with tertiary interventions, some of our interviewees questioned the adequacy of the workforce being tasked with managing the Substance Abuse Crisis.

C. Opportunities

- Policymakers should recognize syringe exchanges and other safe spaces as critical components in the SUD continuum of care and provide resources to better integrate them with treatment and other services.
- Improvement are urgently needed to provide evidence-based treatment to Indiana's jail population.
- As discussed earlier in this report, Care Coordination could play an outsize role in triggering earlier and/or more effective interventions. Similarly, providing basic wrap-around services to those in recovery or during re-entry, such as supportive housing, are a cost-effective method to reduce Indiana's expenditures on treatment and incarceration.
- Additional research is required to evaluate the Indiana workforce tasked with the crisis. Issues that require investigation include scope of practice issues, the number of navigators, counsellors needed to service the SUD populations, and the potential for an increased workforce to adopt innovative interventions based on telemedicine or mobile apps.
- Indiana should look beyond existing healthcare intervention models and explore the potential for, say, county or regional rapid stabilization models of care.
- During the opioid epidemic Indiana policymakers should explore how to reduce administrative barriers to receiving Medicaid services.

3. CARE COORDINATION AND WRAP-AROUND SERVICES

A. Background

Earlier, this report discussed healthcare interventions and argued that harm reduction, diagnosis, treatment, and adherence strategies should be viewed as a continuum of care requiring improvements to or an increase in services across that continuum. This section focuses more narrowly on handoffs between service providers across that care continuum and the barriers that hinder those strategies.

Prior reports, including The Surgeon-General's Report (2016),¹¹³ The President's Commission (2017),¹¹⁴ multiple interviewees from different sectors and expertise areas, and our original research strongly suggest the urgent need to address care coordination and provide wrap-around services. In this section, we address both care coordination (improved integration of clinical care) and wrap-around services (non-clinical services improve patient engagement and treatment compliance, including transportation and housing services). Our interviewees also informed us of broader coordination and infrastructure problems, one noting,

This problem [the current opioid crisis] and other 21st century problems don't really lend themselves to the independent infrastructure that ... now exists. There needs to be more of an interdependent, more of a collaboration between entities ... because so many organizations, domains are affected by this and the problem is there's very little communication between the same agencies within a domain like medicine, let alone between agencies like DCS, medicine, judiciary, mental health...

To a large extent, lack of care coordination or fragmentation of care are defining features of the U.S. healthcare system.¹¹⁵ The need for improved coordination frequently has been cited by organizations such as the National Academies of Science,¹¹⁶ the Agency for Healthcare Research and Quality,¹¹⁷ and the National Quality Forum.¹¹⁸ Successful care coordination has several key pillars, including "access to a range of health care services and providers," effective communications and care plan transitions (hand-offs) between providers, a focus on the patient's needs, the communication of "clear and simple

¹¹³ *Health Care Systems And Substance Use Disorders*, in *FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH*, 6-1 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

¹¹⁴ The President's Commission on Combating Drug Addiction And The Opioid Crisis 79 (Nov. 1, 2017), Office of National Drug Control Policy, President's Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018) (noting the role of care coordination in "Post-overdose ED-based engagement, service linkage, and ongoing support and service coordination by recovery coaches and other peer workers.").

¹¹⁵ See, e.g., *The Promise of Care Coordination: Transforming Health Care Delivery*, FAMILIES, USA (Apr. 2013), http://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf.

¹¹⁶ See, e.g., *Improving Diagnosis in Health Care*, THE NATIONAL ACADEMIES OF SCIENCES ENGINEERING MEDICINE (Sept. 22, 2015), <http://www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx>.

¹¹⁷ *Care Coordination*, AGENCY FOR HEALTHCARE QUALITY AND RESEARCH, <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html> (last visited Mar. 30, 2018).

¹¹⁸ *Care Coordination Measures*, NATIONAL QUALITY FORUM, <http://www.qualityforum.org/ProjectDescription.aspx?projectID=73700> (last visited Mar. 30, 2018).

information that patients can understand,”¹¹⁹ and the effective use of health information technologies.¹²⁰

It is broadly recognized that many of the care coordination issues that present in the SUD context follow from the historic segregation of substance use diagnosis and treatment from mainstream healthcare delivery, with the former frequently thought of as social or criminal justice issues that should be dealt with by psychiatric hospitals or prisons.¹²¹ As we now know, persons suffering from SUD (and frequent co-morbidities such as mental health diseases) are particularly vulnerable populations that in practice require additional and particularly robust levels of care coordination.

B. Findings

Indiana’s response to the opioid epidemic has included several positive steps that should increase care coordination, including data initiatives underway at the Management Performance Hub¹²² and the statewide deployment of the *OpenBeds* program.¹²³

Notwithstanding, our interviewees and/or research identified the following lack of coordination issues that hamper effective diagnosis, treatment, care of those suffering from SUD in Indiana:

- SUD treatment is not a “one-size fits all” model; different patients require different treatment environments and different treatments (including different drug-based treatments), placing a premium on ongoing monitoring and care coordination.
- Diagnosis or even treatment for SUD patients are not end points; SUD patients require ongoing care, including counselling and the provision of wraparound services.
- The treatment of SUD patients is disproportionately exacerbated by factors such as poverty, inadequate/unsafe housing or homelessness, domestic abuse, lack of transportation, and insufficient legal services. Well-funded, coordinated robust wrap-around services can combat these issues.
- Indiana’s expanded Medicaid program (HIP) increases benefits “churn.” Eligible individuals either fail to enroll or, having enrolled fail to make a premium payment and are then (depending on their federal poverty level) locked out or moved to a lower coverage tier. The recent HIP extension invokes increased payments (a tobacco surcharge) and additional administrative requirements associated with timely renewal and community engagement may worsen these phenomena.
- Given the vulnerable SUD population and its frequent overlap with other conditions such as mental illness, HIP Medicaid requirements such as premium payments, identification and other documentation are difficult to navigate without assistance from third-parties such as healthcare providers or life coach coordinators. The same is likely to be the case with future changes to HIP

¹¹⁹ *What Is Care Coordination?*, NEJM CATALYST (Jan. 1, 2017), <https://catalyst.nejm.org/what-is-care-coordination/>.

¹²⁰ *Improved Care Coordination: The Need for Better Improved Care Coordination*, HEALTHIT.GOV, <https://www.healthit.gov/providers-professionals/improved-care-coordination> (last visited Mar. 30, 2018).

¹²¹ *Health Care Systems And Substance Use Disorders*, in FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH, 6-1, 6-5 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

¹²² *Management Performance Hub*, STATE OF INDIANA, <http://www.in.gov/mp/> (last visited Mar. 20, 2018).

¹²³ Kristen Swilley, *Indiana Partners with OpenBeds to Make Rehab Accessible to All*, WCPO CINCINNATI (Mar. 19, 2018), <https://www.wcpo.com/news/state/state-indiana/indiana-partners-with-openbeds-to-make-sure-everyone-who-needs-rehab-can-access-it>.

such as community engagement certification. Given the applicability of the Americans with Disabilities Act to many, even most in the SUD population, Indiana's demonstration program with regard to community engagement likely will require substantial carve-outs, potentially creating more indeterminacy as to Medicaid eligibility.

- A disproportionately large percentage of those incarcerated in Indiana suffer from SUD. It is unclear whether there is effective clinical care coordination with, for example, Medicaid managed care entities (MCEs) occurs upon release.
- There are very few wrap-around services that aid prisoner re-entry by, for example, assisting with serious issues such as employment and housing. Failure to acquire post-release employment exacerbates poverty and is a cause of recidivism.¹²⁴
- Although some providers and insurers have been able to provide limited wrap around services by providing direct financial assistance or employing "life" or "peer" coaches, these services are not reimbursed and are of uncertain sustainability.
- Care coordination is hampered by poorly aligned patient privacy laws and regulations (discussed elsewhere in this report).
- Care coordination requires vastly improved data-sharing across multiple stakeholders including clinical providers and state and local public health agencies.

C. Opportunities

If solving the care coordination problem was as easy as identifying it, fragmentation would not persist as a dominant problem in U.S. healthcare delivery. Equally, general healthcare delivery only recently has begun to integrate previously-siloed services such as mental health and substance-use.

Notwithstanding, in the SUD context and on a shorter timeline there are several approaches that are worth exploring:

- Although federal Medicaid rules do not allow for many wrap-around services, Indiana like any other state is free to fund these services and provide them through Medicaid, albeit without federal matching. If prisoner re-entry, safe and supportive housing, vocational services, etc., are allowed as reimbursable products then managed care and other reimbursed entities will have incentives to act as care coordinators and, importantly, can be subject to accountability.
- Evaluate the provision of wrap-around services for 6-12 months for SUD individuals who successfully complete a treatment program.
- Reduce the care coordination costs currently shifted to Medicaid providers by reexamining premium requirements, administrative requirements, and penalties such as lock-outs and negative HIP tiering for persons with SUD.
- Demonstration projects have identified significant cost-savings in the Medicaid program from the use of care coordination interventions for those with chronic conditions.¹²⁵ Recently, CMS has emphasized its increased flexibility in allowing states to experiment with new care models that can be funded with federal dollars.¹²⁶ The primary vehicle for implementing such models are through the Section 1115 demonstration program that Indiana has now twice successfully

¹²⁴ Adam Looney & Nicholas Turner, *Work and Opportunity Before and After Incarceration*, THE BROOKINGS INSTITUTION (Mar. 2018), available at https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf.

¹²⁵ See, e.g., Jingping Xing, Candace Goehring, & David Mancuso, *Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs*, 34 HEALTH AFFAIRS 653 (2015), available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.0655?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

¹²⁶ See, e.g., Dear Governor Letter from Thomas E. Price and Seema Verma, U.S. Dept. of Health and Human Services, <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>.

leveraged. Indiana should consider making additional waiver requests to provide care coordination services and other wrap-around services.

- Indiana should fund its own demonstration projects to examine novel approaches to providing coordinated care for the SUD population and evaluate their suitability in the Indiana context. Examples include:
 - a. A “hub and spoke” model such as that used by Vermont’s Care Alliance for Opioid Addiction.¹²⁷ This uses a managed care to expand MAT using an integrated model consisting of residential methadone treatment “hubs” and buprenorphine outpatient “spokes.” The “spokes” also include home health and wrap-around services.
 - b. The optional Medicaid State Plan benefit under the Affordable Care Act of 2010, Section 2703. This allows for states to establish “Health Homes” to coordinate care for people with Medicaid who have chronic conditions such as substance abuse and mental health illnesses.
- Indiana should recognize that whatever the policy benefits of new reforms of HIP eligibility and maintenance of benefits are in regard to the general Medicaid population, those same reforms may cause a disproportionate reduction of services for those with SUD and co-morbidities such as mental health illnesses. Indiana should examine the feasibility of delaying the introduction of its eligibility and maintenance of benefits reforms as they apply to this vulnerable population until the substance use crisis shows signs of abatement.
- Medicaid services should be reinstated for individuals 30 days prior to their release from corrections.¹²⁸ This would enable improved, coordinated clinical hand-offs to Medicaid providers and the opportunity for community-based providers to provide wraparound services (such as finding safe and supportive housing) during the critical post-release period of time.

¹²⁷ *The Care Alliance for Opioid Addiction*, VERMONT DEPT. OF HEALTH, <http://www.healthvermont.gov/response/alcohol-drugs/treating-opioid-use-disorder>.

¹²⁸ *Governors' Recommendations for Federal Action to End the Nation's Opioid Crisis*, NATIONAL GOVERNORS ASSOCIATION, 5 (Jan. 18, 2018), available at <https://www.nga.org/files/live/sites/NGA/files/pdf/2018/OGR/NGA%20Recommendations%20for%20Federal%20Action%202018.pdf>.

4. DRUG TAKE BACK PROGRAMS

A. Background

Prescription drug diversion was a key accelerant in the rise of the Substance Abuse Crisis, and remains a prime source of misused opioids.¹²⁹ The National Center on Addiction and Substance Use estimates that at least three of every five prescribed pills are not consumed by the recipient of the prescription,¹³⁰ and the National Institutes of Health (NIH) estimates five out of every seven diverted prescription drugs are obtained from a friend or a relative.¹³¹ Research has shown that those prescribed opioids frequently do not recall receiving information about proper storage and/or disposal of leftover medications when they acquire their prescriptions.¹³² Programs promoting secure storage and disposal of prescription opioids, including drug take back programs, are an important means through which to reduce the diversion and misuse of prescription drugs.

Indiana law authorizes (it does not mandate) the establishment and implementation of local drug take back programs,¹³³ and ninety of Indiana's ninety-two counties have at least one drug take back program. Such programs are often located at local police departments. The U.S. Department of Justice and Drug Enforcement Administration operate a web site that allows individuals to search for controlled substance public disposal locations by zip code,¹³⁴ and Indiana's state government web site offers further public guidance on safe drug and paraphernalia disposal.¹³⁵ The President's Commission on Combating Drug Addiction and the Opioid Crisis encourages expansion of state take back efforts through the establishment of year-round take back sites at hospitals and clinics with onsite pharmacies.¹³⁶

Current Indiana law authorizes the Indiana Board of Pharmacy to oversee drug take back program implementation. That said, there are no obligations to fund such programs under state law. Current federal law helped to establish two national "take back days" to take place in the spring and fall of each year, and the Drug Enforcement Agency encourages communities to partner with area law enforcement on such events.¹³⁷

¹²⁹ Alexandra B. Collins, et al., *Harnessing the Language of Overdose Prevention to Advance Evidence-Based Responses to The Opioid Crisis*, 55 INT. J. DRUG POLICY 77 (2018), available at <https://www.ncbi.nlm.nih.gov/pubmed/29524736>.

¹³⁰ The National Center on Addiction and Substance Abuse, *Ending the Opioid Crisis: A Practical Guide for State Policymakers* (2017), available at <https://www.centeronaddiction.org/addiction-research/reports/ending-opioid-crisis-practical-guide-state-policy-makers>.

¹³¹ Renee C. B. Manworren & Aaron M. Gilson, CE: Nurses' Role in Preventing Prescription Opioid Diversion, 115 AM. J. NURS. 34 (2015), available at https://journals.lww.com/ajnonline/Fulltext/2015/08000/CE___Nurses__Role_in_Preventing_Prescription.21.aspx.

¹³² Alene Kennedy-Hendricks, et al., *Medication Sharing, Storage, and Disposal Practices for Opioid Medications Among US Adults*, 176 JAMA INTERN. MED. 1027 (2016), available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2527388>.

¹³³ Ind. Code § 25-26-23-5 (2017).

¹³⁴ Controlled Substance Public Disposal Locations - Search Utility, <https://www.in.gov/idem/recycle/2343.htm> (last visited Mar. 29, 2018).

¹³⁵ Controlled Substance Public Disposal Locations - Search Utility, <https://www.in.gov/idem/recycle/2343.htm> (last visited Mar. 29, 2018).

¹³⁶ The President's Commission on Combating Drug Addiction And The Opioid Crisis 56 (Nov. 1, 2017), Office of National Drug Control Policy, President's Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

¹³⁷ Controlled Substance Public Disposal Locations - Search Utility, <https://www.in.gov/idem/recycle/2343.htm> (last visited Mar. 29, 2018).

B. Findings

While national programs may help remove unused prescriptions from the community – the DEA reports they have collected more than 456 tons of unused medication through these efforts¹³⁸ – several critiques arise. In the interest of maintaining the confidentiality of the person returning the medications, national take back events prohibit inspection and analyzation of materials returned to take back programs. DEA-sponsored take back events prohibit disposal of illicit drugs or controlled substances possessed illegally, and law enforcement is required to be involved in the take back events. Consequently, individuals wishing to dispose of illicit drugs or controlled substances obtained illegally, or those wishing to avoid a law enforcement interaction, would be unable to participate in DEA national drug-tack back events. Because there are only two events per year (one in the spring and one in the fall), there are several months between events during which unused controlled substances may accumulate in the community.

Research also indicates that individuals appear only to be willing to travel up to six miles to participate in a drug take back program.¹³⁹ While interviewees indicate that some communities have initiated local take back programs, it is unlikely that community access to such programs is uniform statewide. Finally, the President's Commission on Combating Drug Addiction and the Opioid Crisis encourages expansion of state take back efforts through the establishment of year-round take back sites at hospitals and clinics with onsite pharmacies.¹⁴⁰

C. Opportunities

- Indiana and local communities should encourage and increase their support for the development and implementation of more flexible local take back programs that would expand the availability and impact of such supply reduction efforts.

¹³⁸ K. I. Stoddard, et al., Investigating Research Gaps of Pharmaceutical take back Events: An Analysis of take back Program Participants' Socioeconomic, Demographic, and Geographic Characteristics and the Public Health Benefits of Take Back Programs, 59 ENVIRONMENTAL MANAGEMENT 871 (2017), *available at* <https://link.springer.com/article/10.1007/s00267-017-0834-3>.

¹³⁹ K. I. Stoddard, et al., Investigating Research Gaps of Pharmaceutical take back Events: An Analysis of take back Program Participants' Socioeconomic, Demographic, and Geographic Characteristics and the Public Health Benefits of Take Back Programs, 59 ENVIRONMENTAL MANAGEMENT 871 (2017), *available at* <https://link.springer.com/article/10.1007/s00267-017-0834-3>.

¹⁴⁰ The President's Commission on Combating Drug Addiction And The Opioid Crisis 56 (Nov. 1, 2017), Office of National Drug Control Policy, President's Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

5. PATIENT PRIVACY PROTECTIONS

A. Background

Prior reports, including The President’s Commission, 2017,¹⁴¹ multiple interviewees from different domains, and original research strongly suggest a critical lack of alignment between the general medical privacy rules and those that apply to SUD patients.

Consistently, informants suggested that clinical and social determinants data were deficient regarding persons with a SUD. Some informants complained about the absence of data or its poor quality. Others voiced concerns about a lack of clinical data-sharing and/or its interoperability. One serious *legal* barrier frequently mentioned was the lack of alignment between the federal privacy protections relating to medical records generally and those applying to substance use records.

The HIPAA Federal Privacy Rule applies to all patients in most traditional healthcare environments.¹⁴² HIPAA privacy *also* applies to patients being treated for substance use or mental health issues. HIPAA permits broad data-sharing between providers without requiring any patient consent.¹⁴³ The Privacy Rule does not contain any provisions specific to substance use patients. However, the Privacy Rule does contain a special rule relating to some physician-documentation of mental health treatments. This “psychotherapy notes” exception creates a minor exception to the sharing of encounter information or “process notes” as distinct from typical clinical records.¹⁴⁴

The Confidentiality of Alcohol and Drug Abuse Patient Records rule, often referred to as 42 CFR Part 2 (or just “Part 2”), provides an *additional* layer of confidentiality for the records of SUD patients.¹⁴⁵ Part 2 applies to federally-assisted programs that provide SUD programs that diagnosis, treat, or refer. Part 2 can apply to personnel or a unit contained within a general medical facility. Historically, Part 2 has required an additional, highly specific consent from the patient before SUD records may be shared. In 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) updated Part 2 including some changes to the consent process.¹⁴⁶ The updated consent provisions allow for a limited “general” consent contained in the “To Whom” section of the consent, under which a SUD patient may designate certain providers to receive certain, specified SUD information.¹⁴⁷ Technically, the new consent rules operate quite differently from HIPAA and bring with them distinct accountability, research, and other provisions. Although the updated disclosure rule does include a new “medical emergency” exception,¹⁴⁸ even that is not as permissive as the equivalent HIPAA approach. In 2018, SAMHSA revisited some of these issues but again declined to further align HIPAA and Part 2

¹⁴¹ The President’s Commission on Combating Drug Addiction And The Opioid Crisis 121-22 (Nov. 1, 2017), Office of National Drug Control Policy, President’s Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

¹⁴² 45 C.F.R. §§ 160, 162, and 164 (2018).

¹⁴³ 45 C.F.R. § 164.506 (2018).

¹⁴⁴ 45 C.F.R. §§ 164.501, 164.508(a)(2) (2018).

¹⁴⁵ See, Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2 (2018).

¹⁴⁶ Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052 (Jan. 18, 2017).

¹⁴⁷ 42 C.F.R. §§ 2.31, 2.33 (2018).

¹⁴⁸ 42 C.F.R. § 2.51 (2018).

provisions.¹⁴⁹ To further complicate matters some States have passed substance use-specific privacy laws.¹⁵⁰

B. Findings

The differential approach to protecting SUD records is blamed for inadequate integration of full SUD patient data in electronic health records (EHRs), the exclusion of SUD records from statewide sharing through Health Information Exchanges, the perpetuation of stigma by treating SUD patients differently, and the exclusion of SUD patients from potentially beneficial research based on EHR data.¹⁵¹

Interviewees from more than one domain told us that greatest burdens are placed on emergency departments and primary healthcare providers who are called upon to care for SUD patients but without access (or at least easy access) to relevant medical records.

As a matter of policy our literature searches and interviewees were in general agreement that the treatment of SUD (and mental health co-morbidities) must be normalized or mainstreamed. If our healthcare delivery is to move to a position where SUD is treated as a mainstream disease, then segregation of data between SUD populations and other populations should be removed. Indeed, there is some evidence that patients with a substance use history unknown to treating physicians have been put at risk by opioid prescribing.¹⁵² Indeed, one of our interviewees described non-aligned privacy rules as “an albatross,” and compared the resultant delays caused in treating opioid patients as involving risks similar to delays in treating trauma patients.

Continued data segregation has been justified on the grounds that such data are particularly sensitive and that there has been a history of discrimination against SUD patients. For example, The Surgeon-General’s Report noted, “Currently, persons with substance use disorders involving illicit drugs are not protected under anti-discrimination laws, such as the ADA.”¹⁵³ This is partially correct, although SUD is recognized by the ADA as a disability, protection is lost if the person is “currently engaging in the illegal use of drugs.”¹⁵⁴ As noted by SAMHSA, disclosure of SUD information can “lead to a host of negative consequences, including: Loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration.”¹⁵⁵ One of our interviewees noted that opioid patients are particularly fearful of information about their illness being shared with law enforcement and corrections, but less concerned about data sharing between providers.

¹⁴⁹ Confidentiality of Substance Use Disorder Patient Records, 83 Fed. Reg. 239, 241 (Jan. 3, 2018).

¹⁵⁰ See e.g., CAL. HEALTH & SAFETY CODE § 11845.5 (West 2018); see generally RTI INTERNATIONAL, BEHAVIORAL HEALTH DATA EXCHANGE CONSORTIUM (2014) (at bequest of U.S. Dept. of Health and Human Services), available at https://www.healthit.gov/sites/default/files/bhdeconsortiumfinalreport_06182014_508_compliant.pdf.

¹⁵¹ Frakt, A. B., Bagley, N. (2015). *Protection or harm? Suppressing substance-use data*. NEJM, 372, 1879-188

¹⁵² Constance M. Weisner et al., Trends in Prescribed Opioid Therapy for Non-cancer Pain for Individuals with Prior Substance Use Disorders, 145 PAIN, 287 (2009), doi:10.1016/j.pain.2009.05.006.

¹⁵³ *Health Care Systems And Substance Use Disorders*, in FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 6-1, 6-34 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/chapter-6-health-care-systems.pdf>.

¹⁵⁴ 42 U.S.C. § 12114(a) (2017); see also, 42 U.S.C. § 12111(6) (2017).

¹⁵⁵ Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6053. For strong defenses of Part 2, see Paul N. Samuels & Patty McCarthy Metcalf, *Relaxing Patient Privacy Rules Would Worsen the Opioid Epidemic*, STAT NEWS (Nov. 24, 2017), <https://www.statnews.com/2017/11/24/opioid-epidemic-patient-privacy/>; Karla Lopez & Deborah Reid, *Discrimination Against Patients With Substance Use Disorders Remains Prevalent And Harmful: The Case For 42 CFR Part 2*, HEALTH AFFAIRS BLOG, (Apr. 13, 2017), <https://www.healthaffairs.org/do/10.1377/hblog20170413.059618/full/>.

This is also an area adversely affected by *perceived* barriers. In addition to the lack of alignment between the HIPAA Privacy Rule and Part 2, specific provisions of the HIPAA Privacy Rule are cited by providers as reasons not to share patient information even when there is no real legal barrier. For example, one interviewee noted that HIPAA's very limited "psychotherapy notes" exception discussed above can result in blanket refusals to share mental health information.

C. Opportunities

This is not a newly identified problem and there have been unsuccessful attempts to pass legislation to provide regulatory authority to better align the rules.¹⁵⁶ As HHS rolls out regulations and policies authorized under the 21st Century Cures Act to promote interoperability,¹⁵⁷ discourage "information blocking,"¹⁵⁸ and establish a Trusted Exchange Framework¹⁵⁹ more and improved clinical sharing inevitably will result and may, in the future, lead to some consensus on how to proceed with the differential laws.

However, the current barriers to sharing SUD information (both real and perceived) must be addressed on a *far shorter timeline*. Waiting for a political consensus to develop that would abandon the disparate federal protections is infeasible. Rather, the issue must be engaged at the level of transparent, actionable regulatory guidances.

HHS's Office of Civil Rights (OCR) has published FAQs encouraging sharing and, more recently issued a "clarifying" Opioid Crisis Guidance that notes the flexibility in the HIPAA rule that permits providers to disclose information to families in dangerous or emergency situations and that a patient's personal representative (recognized as such by state law) has the same rights as the patient.¹⁶⁰ However, the Guidance does not address the relationship between HIPAA and the more stringent Part 2. Equally, SAMHSA has issued a FAQ on the interrelationship of Part 2 and Health Information Exchange.¹⁶¹ This dichotomous approach is clearly insufficient.

HHS stakeholders (ONC, SAMHSA, and OCR-Civil Rights) should be instructed to coordinate their work and publish detailed and comprehensive *joint* guidances for providers, health information exchanges, and patients. These guidances should at the least:

- Clarify the limited role of the "psychotherapy notes" provision and instruct providers that it does not justify a refusal to share substance use or mental health records.
- Clarify in detail how the "emergency" carve-outs in the two regulations operate and provide detailed instructions on how to navigate them and document interventions.

¹⁵⁶ *E.g.*, Helping Families in Mental Health Crisis Act of 2016, H.R. 2646, 114th Cong. (2016); Overdose Prevention and Patient Safety Act of 2017, H.R. 3545, 115th Cong. (2017).

¹⁵⁷ 42 U.S.C. § 300jj (2017).

¹⁵⁸ 42 U.S.C. § 300jj-52(a) (2017).

¹⁵⁹ OFFICE OF THE NAT'L COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, DRAFT TRUSTED EXCHANGE FRAMEWORK (2018), *available at* <https://www.healthit.gov/sites/default/files/draft-trusted-exchange-framework.pdf>

¹⁶⁰ HHS Office for Civil Rights Issues Guidance on How HIPAA Allows Information Sharing to Address the Opioid Crisis, HHS.gov (Oct. 27, 2017), <https://www.hhs.gov/about/news/2017/10/27/hhs-office-civil-rights-issues-guidance-how-hipaa-allows-info-sharing-address-opioid-crisis.html>.

¹⁶¹ LEGAL ACTION CENTER, APPLYING THE SUBSTANCE ABUSE CONFIDENTIALITY REGULATIONS TO HEALTH INFORMATION EXCHANGE (HIE) (2010) (at bequest of U.S. Dept. Health and Human Services), *available at* <https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf>.

- Identify and promote specific, lawful data-sharing frameworks and technical workflows that handle the different consent provisions and minimize the barriers caused by the differential protections. This likely will require a rapid consultation process with EHR vendors to incorporate these into their software. The goal of this process should be to design workflows that, in practice, allow clinicians to treat patients with SUD without concerns over compliance with differing regulatory systems.
- OCR and SAMHSA should issue explicit joint enforcement guidance that minimize clinicians' concerns over the legal implications of dealing with these privacy laws.

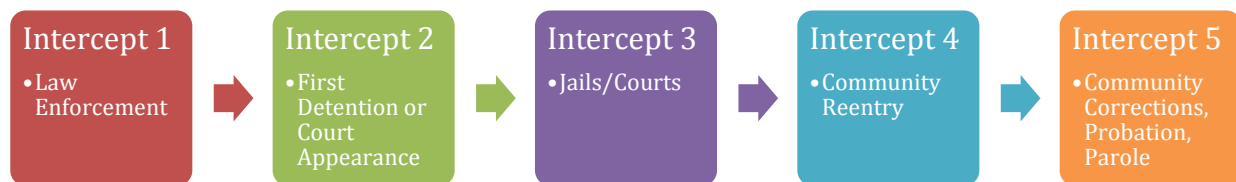
6. COURTS

A. Background

Substance use disorder is prevalent in our criminal court systems. According to the Bureau of Justice Statistics, 5% of the general population above the age of 18 is substance dependent, whereas “[m]ore than half (58%) of state prisoners and two-thirds (63%) of sentenced jail inmates me[e]t the criteria for drug dependence or abuse.”¹⁶² While a significant proportion of the population in the criminal justice system for drug-related offenses meet the clinical criteria for drug dependence or abuse, more than one out of every two persons in state prisons and jails for violent crimes, and two of every three persons in prison or jail for property-related crimes, also meet that definition. One interviewee involved in the criminal courts estimated almost all cases seen in a particular court were “drug cases,” as “between 85 and 95 percent” of the thefts, shoplifting, prostitution, home invasions and other lower level felonies were committed in pursuit of a way to pay for the drugs the person needed to avoid withdrawal symptoms, with some arrestees having “three, four, or five” cases pending at the same time.¹⁶³ Numerous interviewees, including all involved with the court systems, spontaneously shared a similar belief to that expressed by one interviewee: “Everyone in the judicial system knows we cannot jail ourselves out of this situation.”

B. Findings

1. Sequential Intercept Model Criminal Justice Intercept Points for SUD Interventions (SAMHSA 2015)



The Sequential Intercept Model is recommended in the research as a framework to move the management of mental health and substance use disorder concerns outside the traditional criminal justice system and into health care and support services in the community. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the model focuses on five “intercept” points where interventions are possible: (1) Law Enforcement; (2) Initial detention/first court appearance; (3) Jails/courts; (4) Reentry from detention into the community; and (5) Community corrections, probation, and parole.¹⁶⁴

¹⁶² Jennifer Bronson et al., *Drug Use, Dependence, And Abuse Among State Prisoners and Jail Inmates, 2007-2009*, U.S. Dept. of Justice, at 1 (2017) available at <https://www.bjs.gov/content/pub/pdf/dudaspi0709.pdf>.

¹⁶³ See Pedro Mateu-Gelabert et al., *Strategies to Avoid Opiate Withdrawal: Implications for HCV and HIV Risks*, 21 THE INTERNATIONAL J. DRUG POLICY 179 (2010), available at <http://doi.org/10.1016/j.drugpo.2009.08.007>.

¹⁶⁴ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, MUNICIPAL COURTS: AN EFFECTIVE TOOL FOR DIVERTING PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS FROM THE CRIMINAL JUSTICE SYSTEM, HHS Publication No. (SMA)-15-4929 (2015), available at <https://store.samhsa.gov/shin/content/SMA15-4929/SMA15-4929.pdf>.

2. Application of Sequential Intercept Model

Strides have been made to implement evidence-based programs at many of the SAMHSA intercept points. Interviewees pointed to such programs as Crisis Intervention Teams for mental health services and the Deflection Team Model adopted in jurisdictions in other states for substance use disorder¹⁶⁵ (Intercept 1), and mental health, drug, and veterans courts (Intercept 3). In 2013, almost 26,000 Hoosiers were admitted to substance use treatment programs; 47% of program referrals were from our criminal justice system.¹⁶⁶

Indiana also has begun a pilot program in three counties that would allow for involuntary commitment proceedings to be brought against persons with a substance use disorder and would allow a person revived with naloxone who has been charged with or convicted of narcotic possession to be enrolled in a diversion program.¹⁶⁷ Many states are implementing such involuntary treatment laws; however, there is no evidence that they are more effective than non-voluntary treatment interventions.¹⁶⁸ In addition to limited demonstration of effectiveness, questions concerning such programs arise about local capacity, reinforcement of substance use-related stigma, as well as how such interventions affect individual civil rights.¹⁶⁹

Intercepts 4 and 5, the periods when the person moves from detention back to the community, are points of extreme risk for persons with substance use disorder. The experience of our interviewees engaged with the courts and criminal justice system echoes the evidence from the research, “Prisoners’ reentry – their return to the community from prison – can be stressful as former inmates try to obtain housing, reintegrate into their families and communities, find employment, and gain access to health care.”¹⁷⁰ The two weeks following release from prison is a period of particular vulnerability; a study from Washington state found prisoners were as much as *129 times* more likely to die of a drug overdose during that time than those in the general population.¹⁷¹ Interviewees described the significant strides taken in the past two years by the Indiana Department of Correction to improve the addiction treatment

¹⁶⁵ See, e.g., *For Addicts And Their Friends, Families, and Caregivers*, GLOUCESTER POLICE DEPT., <http://gloucesterpd.com/addicts/> (discussing the Angel program) (last visited Mar. 20, 2018); Jessica Reichert, *Fighting the Opioid Crisis through Substance Use Disorder Treatment: A Study of a Police Program Model in Illinois*, ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY (Sep. 7, 2017), available at <http://www.icjia.state.il.us/articles/fighting-the-opioid-crisis-through-substance-use-disorder-treatment-a-study-of-a-police-program-model-in-illinois>.

¹⁶⁶ HAROLD KOOREMAN & MARION GREENE, TREATMENT & RECOVERY FOR SUBSTANCE USE DISORDERS IN INDIANA, IND. UNIV. CTR. FOR HEALTH POLICY 16-H80 (Lyndy Kouns ed., 2016), available at <https://fsph.iupui.edu/doc/researchcenters/Treatment%20and%20Recovery%202016.pdf>.

¹⁶⁷ Substance Abuse—Medical Care and Treatment—Opioid Treatment Pilot Program, 2017 Ind. Legis. Serv. P.L. 125-2017 (S.E.A. 499) (West).

¹⁶⁸ D. Werb et al., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 *The International J Drug Policy* 1 (2016), available at <http://doi.org/10.1016/j.drugpo.2015.12.005>.

¹⁶⁹ Christine Vestal, *Support Grows for Civil Commitment of Opioid Users*, THE PEW CHARITABLE TRUSTS (Jun. 15, 2017), available at <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/06/15/support-grows-for-civil-commitment-of-opioid-users>; Joseph Paul, *Indiana’s Controversial Plan to Keep Opioid Addicts Out of Jail or Cemetery*, JOURNAL & COURIER (Oct. 26, 2017), available at <https://www.jconline.com/story/news/2017/10/26/new-program-lets-counties-use-involuntary-commitment-laws-opioid-addiction/548074001/>.

¹⁷⁰ Ingrid A. Binswanger, et al., *Release From Prison—A High Risk of Death for Former Inmates*, 356 N ENGL J MED 157, 157 (2007), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/#!po=1.28205>.

¹⁷¹ Ingrid A. Binswanger, et al., *Release From Prison—A High Risk of Death for Former Inmates*, 356 N ENGL J MED 157 (2007), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/#!po=1.28205>.

and recovery services available to the incarcerated, including bolstering the evidence-informed treatments available to inmates preparing to reenter the community (Intercept 4).¹⁷²

Interviewees noted that while much of the current research and intervention efforts focus on the rise in use of opioids such as heroin and fentanyl, many Indiana communities continue to see populations with high usage rates of methamphetamine, cocaine, and other drugs as well. These interviewees also confirmed evidence found in the research that there remain significant gaps in, or barriers to, access, continuity, and availability of services for persons with substance use disorder in state criminal justice systems. Challenges noted include: (a) insufficiency of outpatient mental health and SUD treatment facilities, especially those providing Medication Assisted Treatment (MAT); (b) lack of reliable systems to identify where openings for care are available; (c) the need for further education across the judicial and criminal justice systems framing the Substance Abuse Crisis as a health issue, rather than exclusively a law and order issue, and the benefits and effectiveness of MAT as a part of treatment (especially in comparison to detox, abstinence, and/or counseling alone); (d) the affordability of services, with those in need of care frequently lacking the resources and/or insurance benefits to afford the costs associated with receiving or maintaining community-based services. As stated by one interviewee within the criminal justice system, “Most of whom we serve are indigent – any cost is an impediment” to their treatment and recovery.

In addition, several interviewees noted the tension between criminal law, child welfare programs, landlords, and some employers and the use of Medication Assisted Treatment as part of community-based recovery. Several of the medications used in Medication Assisted Treatment programs are opioids, therefore the presence of maintenance medications (such as methadone) in a person’s blood or urine sample may be treated by some actors within these programs the same way as if heroin or fentanyl were to be found, affecting the person’s ability to drive, maintain “clean” test samples, obtain or maintain both housing and employment.

Drug courts are effective in reducing substance use and the likelihood of overdose for persons in the criminal justice system who have committed non-violent crimes, especially when compared to the outcomes for persons committing comparable crimes who are not diverted to the drug court system.¹⁷³ Indiana has a strong drug court system in place; those drug courts in place are running at or near full capacity, although some underserved areas of the state remain. The President’s Commission on Combating Drug Addiction and the Opioid Crisis strongly supports the drug court system, recommending in its final report all substance use-related violations of probation or parole be diverted to drug courts and states establish drug courts in every county in every state.¹⁷⁴ The Commission notes, “The principal factors limiting drug court expansion are insufficient funding, treatment, and supervision resources, not a lack of judicial interest.”¹⁷⁵

¹⁷² *Addiction Recovery Services*, Indiana Department of Corrections, available at <http://www.in.gov/idoc/3490.htm>.

¹⁷³ The President’s Commission on Combating Drug Addiction And The Opioid Crisis (Nov. 1, 2017), Office of National Drug Control Policy, President’s Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

¹⁷⁴ The President’s Commission on Combating Drug Addiction And The Opioid Crisis 10 (Nov. 1, 2017), Office of National Drug Control Policy, President’s Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

¹⁷⁵ The President’s Commission on Combating Drug Addiction And The Opioid Crisis 73 (Nov. 1, 2017), Office of National Drug Control Policy, President’s Commission: Final Draft, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ondcp/presidents-commission/> (last visited Mar. 26, 2018).

Indiana certified drug courts must follow the procedural and structural best practice standards promulgated by the National Association of Drug Court Professionals.¹⁷⁶ While drug courts and other specialty diversion courts are worth highlighting for their effectiveness, interviewees note they are not for everyone and should not be seen as a cure all for the problems of substance use disorder related to criminal activity. Interviewees cite similar limits to the drug court system due to insufficient funding, treatment, and supervision as identified in the President's Commission report. Interviewees also noted the following issues: (a) drug courts are not meant for all persons with substance use disorder concerns in the criminal justice system; (b) there is significant variation in entry standards across drug courts; (c) while all courts must permit program enrollees to access the evidence-based practice of MAT for substance use, interviewees note that courts vary in their relative MAT-friendliness, and communities vary on the type and availability of service provider partners and wrap around services. Furthermore, while research recognizes the most effective MAT approach will be customized to the particular patient,¹⁷⁷ and treatments such as buprenorphine and methadone have been found in studies by other states¹⁷⁸ to be far more cost effective than Vivitrol (long-acting, injectable naltrexone), some courts have demonstrated an explicit preference for one form of MAT over others,¹⁷⁹ perhaps due in part to education efforts by drug manufacturers directed at judges.¹⁸⁰

Multiple interviewees discussed the challenges that have arisen in the wake of Indiana's criminal code reform in 2015,¹⁸¹ which reclassified nonviolent offenses and shifted these low-level felony cases away from the state Department of Correction to local jails and community corrections and probation. Since the shift, there has been a rapid rise in the felony population in the jail system.¹⁸² The jail systems are not equipped, nor are they robustly funded, to offer substantive substance use disorder treatment services, especially in comparison to the state Department of Correction. Consequently, because of the lack of treatment during time in jail, many charged with or convicted of low level felonies may be at particularly high risk of overdose and death as they are left without the establishment of "warm handoffs" that can facilitate treatment uptake between jail and community providers. Interviewees noted the difficulty of identifying quality community-based treatment program openings (both inpatient and outpatient) from the bench and would welcome additional support for addressing substance use disorder through evidence-informed resources such as bench books.

C. Opportunities

¹⁷⁶ National Drug Court Institute, National Association of Drug Court Professionals, Adult Drug Court Best Practice Standards (Vol. I and II) (2013), available at <https://www.ndci.org/resources/publications/standards/>.

¹⁷⁷ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., DEPT. HEALTH AND HUMAN SERVICES, IN BRIEF 8(1), ADULT DRUG COURTS AND MEDICATION-ASSISTED TREATMENT FOR OPIOID DEPENDENCE (2014), available at <https://store.samhsa.gov/shin/content/SMA14-4852/SMA14-4852.pdf>.

¹⁷⁸ *Long-Acting Injectable Medications for Alcohol and Opioid Use Disorders: Benefit-Cost Findings*, Washington State Institute for Public Policy (2016), available at http://www.wsipp.wa.gov/ReportFile/1650/Wsipp_Long-Acting-Injectable-Medications-for-Alcohol-and-Opioid-Use-Disorders-Benefit-Cost-Findings_Report.pdf.

¹⁷⁹ Christian Sheckler, *New Treatment Options Spring Up for Heroin, Opioids But Crisis Far from Over*, SOUTH BEND TRIBUNE (Jun. 4, 2017), https://www.southbendtribune.com/news/publicsafety/new-treatment-options-spring-up-for-heroin-opioids-but-crisis/article_7b7e1d1c-6c38-5a25-a805-e4e51e9ee924.html.

¹⁸⁰ Jake Harper, *To Grow Market Share, A Drugmaker Pitches Its Product To Judges*, NPR.ORG (August 3, 2017), <https://www.npr.org/sections/health-shots/2017/08/03/540029500/to-grow-market-share-a-drugmaker-pitches-its-product-to-judges>.

¹⁸¹ House Enrolled Act 1006 (2015), available at <https://iga.in.gov/static-documents/2/1/b/8/21b8684f/HB1006.06.ENRH.pdf>.

¹⁸² Dave Stafford, *Criminal Code Reform Packs Jails with Level 6 Felony Inmates*, THE INDIANA LAWYER, (Sept. 20, 2017), <https://www.theindianalawyer.com/articles/44852-criminal-code-reform-packs-jails-with-level-6-felony-inmates>.

Continued improvement of the court-system response to the Substance Abuse Crisis would benefit from research in the following areas:

- Assessment of the knowledge, attitudes, beliefs, and behaviors of those working in the court systems related to Medication Assisted Treatment and Substance Use Disorder more generally;
- Evaluation of the variation in entry requirements for the state's drug courts;
- An updated assessment of the decade-old, limited outcomes evaluation of Indiana's state drug courts;
- The effectiveness of using the Indiana 2-1-1 system (or the expansion of the new 2-1-1/*OpenBeds* program) to aid in identifying area inpatient and community-based treatment options for those with community-based sentences and/or probation; and,
- Identification and evaluation of court policies addressing the interaction of judges with pharmaceutical and medical device representatives.

7. PROCEEDS FROM OPIOIDS LITIGATION

A. Background

Hundreds of lawsuits have been filed against prescription opioid manufacturers and other participants in the drug supply chain across federal and state courts across the country. Manufacturers of prescription opioids face suit on a variety of claims, including “design” allegations such as failure to include an antagonist ingredient, failure to warn about addiction risks, and misrepresentations about the drugs’ safety.¹⁸³ Increasingly, plaintiffs are basing their claims on allegations that (1) manufacturers ignored signs of or failed to investigate suspiciously large orders, and (2) the pharmaceutical industry exaggerated the benefits of long-term use of opioid pain relievers, while minimizing their addictive risks.¹⁸⁴ The pool of defendants also is increasing with, for example, intermediaries in the drug supply chain, such as pharmacy benefit managers, being added to the lawsuits.¹⁸⁵

More than 40 state attorney generals are either investigating¹⁸⁶ or actively litigating these claims against participants in the drug supply.¹⁸⁷ In addition, throughout the country, multiple cities, counties, and tribal nations have brought actions against those participants.¹⁸⁸ In Indiana, at least ten cities, including Indianapolis, and several counties have filed such lawsuits.¹⁸⁹ The state of Indiana has contracted with a national litigation firm to “bolster the state’s legal analysis and litigation experience in this complex area of opioid accountability.”¹⁹⁰ The recently enrolled Indiana Senate Bill No. 188 requires a report from the Attorney-General not later than July 1, 2018 as to whether to join the litigation.¹⁹¹

In December 2017, the United States Judicial Panel on Multidistrict Litigation consolidated most federal claims (already numbering over 400) in the Northern District of Ohio before US District Judge Daniel

¹⁸³ Rebecca L. Haffajee & Michelle M. Mello, *Drug Companies’ Liability for the Opioid Epidemic*, 24 NEW ENGLAND J. MED. 377 (2017).

¹⁸⁴ Andrew Kolodny, et al, *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANNU. REV. PUBLIC HEALTH 559 (2015).

¹⁸⁵ Casey Ross, *A South Texas County Drags PBMs into Nationwide Lawsuit Over Opioids*, STAT NEWS (Feb. 26, 2018), <https://www.statnews.com/2018/02/26/texas-pbm-opioid-lawsuit/>.

¹⁸⁶ Press Release, Attorney General Eric T. Schneiderman, A.G. Schneiderman, Bipartisan Coalition of AGs Expand Multistate Investigation Into Opioid Crisis (Sept. 19, 2017), available at <https://ag.ny.gov/press-release/ag-schneiderman-bipartisan-coalition-ags-expand-multistate-investigation-opioid-crisis>.

¹⁸⁷ *Overview of State Litigation to Combat the Opioid Epidemic*, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS (Feb. 22, 2017), <http://www.astho.org/StatePublicHealth/Overview-of-State-Litigation-to-Combat-the-Opioid-Epidemic/02-22-18/>.

¹⁸⁸ See, e.g., Mitch Smith & Monica Davey, *With Overdoses on Rise, Cities and Counties Look for Someone to Blame*, N.Y. TIMES (Dec. 20, 2017), <https://www.nytimes.com/2017/12/20/us/opioid-cities-counties-lawsuits.html?mtrref=www.google.com&auth=login-email>; *Native American tribes sue opioid manufacturers, distributors*, CBS NEWS (Jan. 9, 2018), <https://www.cbsnews.com/news/native-american-tribes-sue-opioid-manufacturers-distributors/>.

¹⁸⁹ See, e.g., Ryan Martin, *Opioid epidemic: 10 Indiana Cities Suing Pharmaceutical Companies*, INDYSTAR (Jan. 8, 2018), <https://www.indystar.com/story/news/crime/2018/01/08/noblesville-sues-pharmaceutical-companies-seeking-relief-incredible-harm-caused-opioid-epidemic/1012598001/>; John Russell, *Nearly a Dozen Indiana Communities Sue Opioid Industry in New Flurry of Suits*, INDIANA BUSINESS JOURNAL (Jan. 8, 2018), <https://www.ibj.com/articles/66962-nearly-a-dozen-indiana-communities-sue-opioid-industry-in-new-flurry-of-suits>.

¹⁹⁰ Olivia Covington, *AG’s Office Contracts with National Firm to Consider Opioid Litigation*, INDIANA LAWYER (Feb. 15, 2018), <https://www.theindianalawyer.com/articles/46170-ags-office-contracts-with-national-firm-to-consider-opioid-litigation>.

¹⁹¹ S.B. 188, 120th Gen. Assembly, – 2nd Reg. Sess. (Ind. 2018), available at <https://iga.in.gov/legislative/2018/bills/senate/188#digest-heading>.

Polster.¹⁹² On March 1, 2018, the U.S. Department of Justice filed a statement of interest requesting Judge Polster to grant it time to consider whether the federal government would participate in the litigation,¹⁹³ eventually deciding on an amicus relationship.¹⁹⁴ Several settlement conferences have been scheduled and there are reports of ongoing settlement talks between the parties.¹⁹⁵ Additionally, Judge Polster has informed the parties that he wants to see a settlement in 2018.¹⁹⁶ Complications include dealing with unconsolidated suits filed in state courts and whether settlement funds also should be allocated among counties or cities that have not yet filed suit.¹⁹⁷

Although the plaintiffs have begun to calculate the losses caused to their budgets and communities and how the attorneys involved will be compensated and settlement negotiations continue,¹⁹⁸ the need for public discussion on the use of potential settlement or litigation proceeds remains paramount. Indeed, “[e]xperience suggests that the challenge will be ensuring that the windfalls to state governments are not diverted to unrelated purposes.”¹⁹⁹

B. Findings

In many ways, the opioid litigation is tracking the 1990s tobacco litigation initiated by state attorneys general against several major tobacco companies.²⁰⁰ The opioid litigation may face a similar challenge related to the use of any recovered funds. In November, 1998, the major tobacco companies and settling states entered into *The Tobacco Master Settlement Agreement* (MSA).²⁰¹ Under the MSA, states will receive approximately \$246 billion during the first 25 years of the settlement;²⁰² thereafter, payments will continue in perpetuity. Indiana receives approximately \$130 million each year.²⁰³ Between 1998 and 2017, Indiana received approximately \$2.4 billion.

¹⁹² In Re: National Prescription Opiate Litigation, MDL No. 2804, <http://www.jpml.uscourts.gov/sites/jpml/files/MDL-2804-Initial-Transfer-11-17.pdf>; See, also, Jan Hoffman, *Can This Judge Solve the Opioid Crisis?*, N.Y. TIMES (Mar. 5, 2018), <https://www.nytimes.com/2018/03/05/health/opioid-crisis-judge-lawsuits.html>.

¹⁹³ Nate Raymond, *U.S. Seeks Time to Consider Joining Opioid Litigation*, REUTERS (Mar. 2, 2018), <https://www.reuters.com/article/us-usa-justice-opioids/u-s-seeks-time-to-consider-joining-opioid-litigation-idUSKCN1GE2CO>.

¹⁹⁴ *Justice Department Seeks Role in Opioid Settlement Talks*, REUTERS, Apr. 2, 2018, <https://www.nytimes.com/reuters/2018/04/02/us/02reuters-usa-opioids-litigation.html?>

¹⁹⁵ Jef Feeley & Jared S. Hopkins, *Purdue Pharma Discloses Negotiations With AGs on Opioids*, BLOOMBERG (Nov. 30, 2017), <https://www.bloomberg.com/news/articles/2017-11-30/opioid-lawyers-warned-by-judge-cases-face-serious-hurdles>.

¹⁹⁶ *Plaintiff Lawyers See Nationwide Settlement As Only End For Opioid Lawsuits*, FORBES (Mar. 6, 2018), <https://www.forbes.com/sites/legalnewsline/2018/03/06/plaintiff-lawyers-see-nationwide-settlement-as-only-end-for-opioid-lawsuits/2/#1718d4d54951>.

¹⁹⁷ *Plaintiff Lawyers See Nationwide Settlement As Only End For Opioid Lawsuits*, FORBES (Mar. 6, 2018), <https://www.forbes.com/sites/legalnewsline/2018/03/06/plaintiff-lawyers-see-nationwide-settlement-as-only-end-for-opioid-lawsuits/2/#1718d4d54951>.

¹⁹⁸ *Plaintiff Lawyers See Nationwide Settlement As Only End For Opioid Lawsuits*, FORBES (Mar. 6, 2018), <https://www.forbes.com/sites/legalnewsline/2018/03/06/plaintiff-lawyers-see-nationwide-settlement-as-only-end-for-opioid-lawsuits/2/#1718d4d54951>.

¹⁹⁹ Rebecca L. Haffajee & Michelle M. Mello, *Drug Companies' Liability for the Opioid Epidemic*, 377 NEW ENGLAND J. MED. 2301, 2305 (2017).

²⁰⁰ Rebecca L. Haffajee and Michelle M. Mello, *Drug Companies' Liability for the Opioid Epidemic*, 377 NEW ENGLAND J. MED. 2301 (2017).

²⁰¹ Master Settlement Agreement (Jul. 2014), <http://www.naag.org/assets/redesign/files/msa-tobacco/MSA.pdf>.

²⁰² *A State-by-State Look at the 1998 Tobacco Settlement 19 Years Later*, CAMPAIGN FOR TOBACCO-FREE KIDS (Dec. 13, 2017), <https://www.tobaccofreekids.org/what-we-do/us/statereport>.

²⁰³ *Actual Tobacco Settlement Payments Received by the States (in millions)*, KAISER FAMILY FOUNDATION, <https://www.kff.org/health-costs/state-indicator/tobacco-settlement->

The recitals under the MSA contained strong language suggesting the purpose of the settlement and the intended use of its proceeds by the states.²⁰⁴ However, the agreement contained no specific or detailed language requiring the States to use the proceeds for specific tobacco-related or public health purposes. In the intervening years it has become apparent that only a very small percentage of the settlement funds have been used to encourage smoking cessation or otherwise increase related public health. In 2007, the U.S. Government Accounting Office found that, on average, states allocated 30 percent of their settlement moneys to healthcare (including funding Medicaid and making payments to providers) and 22.9 percent to cover budget deficits.²⁰⁵ Other uses included education and infrastructure projects, with only 3.5 per cent being used for tobacco control.²⁰⁶ One state even used \$42 million to help modernize tobacco farmers.²⁰⁷ It is hard to argue with the conclusion that “MSA resources have been significantly diverted from tobacco control and treatment into other state policy activities.”²⁰⁸

Indiana law directs all MSA funds to ISDH and, while requiring the department to develop a mission statement concerning prevention and reduction of tobacco use and products, does not direct how or what funds should be allocated.²⁰⁹ Indiana spent \$5.9 million on tobacco prevention in 2017 and \$7.5 million in 2018.²¹⁰ Even that latter figure is only 10 per cent of CDC’s recommended spend and is less than 3 percent of the tobacco industry’s marketing spend in Indiana for 2018 (\$277.2 million).²¹¹

Lawsuits brought against the opioid industry routinely reference the financial costs suffered by our communities. For example, the City of Indianapolis complaint requests compensation for “past and future costs to abate the ongoing public nuisance caused by the opioid epidemic [and] damages caused by the opioid epidemic” and a Defendant-funded “abatement fund” for the purposes of abating “the opioid nuisance.”²¹² However, this and other filed complaints generally lack any commitment to how such compensatory funds will be allocated.

There are some positive signs that Indiana recognizes the moral imperative that opioid-derived funds should be used to ameliorate the harms caused by the crisis. For example, in 2016, then Attorney

payments/?currentTimeframe=3&selectedRows=%7B%22states%22:%7B%22indiana%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Mar. 30, 2018).

²⁰⁴ See, e.g., Master Settlement Agreement, at 1-2 (Jul. 2014), <http://www.naag.org/assets/redesign/files/msa-tobacco/MSA.pdf>.

²⁰⁵ *Tobacco Settlement: States’ Allocations of Payments from Tobacco Companies for Fiscal Years 2000 Through 2005*, U.S. GOVERNMENT ACCOUNTING OFFICE, GAO-07-534T (Feb. 27, 2007), <https://www.gao.gov/assets/120/115580.pdf>.

²⁰⁶ *Tobacco Settlement: States’ Allocations of Payments from Tobacco Companies for Fiscal Years 2000 through 2005*, U.S. GOVERNMENT ACCOUNTING OFFICE, GAO-07-534T (Feb. 27, 2007), <https://www.gao.gov/assets/120/115580.pdf>.

²⁰⁷ Jim Estesock, *How the Big Tobacco Deal Went Bad*, NY TIMES (Oct. 6, 2014), <https://www.nytimes.com/2014/10/07/opinion/how-the-big-tobacco-deal-went-bad.html>.

²⁰⁸ Walter J. Jones & Gerard A. Silvestri, *The Master Settlement Agreement and Its Impact on Tobacco Use 10 Years Later: Lessons for Physicians About Health Policy Making*, 137 CHEST 692, 698 (2010), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3021365/>. See, also, Jayani Jayawardhana et. al., *Master Settlement Agreement (MSA) Spending and Tobacco Control Efforts*, PLoS ONE, 9(12) (Dec. 2012).

²⁰⁹ IND. CODE § 4-12-4-11 (2018).

²¹⁰ *Indiana’s Tobacco Revenue, CDC Recommended Spending, State Spending and Tobacco Industry Marketing*, CAMPAIGN FOR TOBACCO-FREE KIDS, <https://www.tobaccofreekids.org/what-we-do/us/statereport/indiana>.

²¹¹ *Indiana’s Tobacco Revenue, CDC Recommended Spending, State Spending and Tobacco Industry Marketing*, CAMPAIGN FOR TOBACCO-FREE KIDS, <https://www.tobaccofreekids.org/what-we-do/us/statereport/indiana>. See, also, *Broken Promises to Our Children: A State-by-State Look at The 1998 State Tobacco Settlement 16 Years Later*, CAMPAIGN FOR TOBACCO-FREE KIDS, https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_brokenpromises_report.pdf.

²¹² Complaint at 166, *City of Indianapolis v. Purdue Pharma L.P.*, (S.D. Ind., Nov. 14, 2017).

General Zoeller made available \$400,000 to equip first responders with naloxone.²¹³ Importantly, those funds were financed from settlement funds received by the Attorney General because of off-label and deceptive marketing by pharmaceutical companies.²¹⁴

C. Opportunities

- Indiana stakeholders should aggressively demand and support the inclusion of language in any opioids settlement that directs the majority of settlement funds to be spent on the treatment of those suffering from SUD, children born with Neonatal Abstinence Syndrome and, through spending on healthcare preventative services and improving the social determinants of health, the creation of healthier environments that will reduce the likelihood of future substance use outbreaks.
- Indiana should signify a similar commitment to such uses of opioid settlement funds by passing legislation that commits the state to responsible and relevant “best practices” expenditures that prioritize substance use harm reduction, treatment, and education.

²¹³ *Attorney General Zoeller Announces Additional Grant for Training, Equipping First Responders with Naloxone*, STATE OF INDIANA (Oct. 5, 2016), http://www.in.gov/activecalendar/EventList.aspx?fromdate=1/1/2018&todate=1/31/2018&display=Month&type=public&eventidn=252940&view=EventDetails&information_id=251762&print=print.

²¹⁴ *Attorney General Zoeller Announces Additional Grant for Training, Equipping First Responders with Naloxone*, STATE OF INDIANA (Oct. 5, 2016), http://www.in.gov/activecalendar/EventList.aspx?fromdate=1/1/2018&todate=1/31/2018&display=Month&type=public&eventidn=252940&view=EventDetails&information_id=251762&print=print.

8. STIGMA

Stigma is a dynamic multidimensional, multilevel phenomenon that occurs at three levels of society — structural (laws, regulations, policies), public (attitudes, beliefs, and behaviors of individuals and groups), and self-stigma (internalized negative stereotypes).²¹⁵

A. Background

Issues related to mental health and substance use disorder historically have been stigmatized in our society. Research demonstrates myriad ways that negative attitudes, beliefs, and behaviors toward substance use disorder undermine the adoption, implementation, and effectiveness of evidence-based and evidence-informed policies to address the opioids crisis. Stigmatization, which can be found in laws and policies; attitudes, beliefs and behaviors; and in the ways one views one's self, has been found to increase barriers to recovery and community integration, and decrease an individual's pursuit of work and help.²¹⁶ These research findings are reinforced by the comments made by multiple interviewees, who have experienced or witnessed the adverse effects that arise out of stigmatizing mental health and/or SUD-related concerns.

As noted in the above quotation, stigma can present itself in the SUD crisis in various forms and permeates across the law and policy areas outlined above. Presentations include: (a) the framing of behaviors associated with substance use disorder and mental health concerns as the manifestation of individual moral failings, rather than as a health concern, medical illness, or symptoms of a brain disease²¹⁷; and (b) the perception of management of substance use disorder as a binary state (that you are either "clean" of drugs or addicted, you demonstrate strength or weakness), rather than recognizing that substance use treatment²¹⁸ and recovery²¹⁹ may involve both setbacks and maintenance therapy. These and other manifestations of stigma contribute to the marginalization of our vulnerable fellow Hoosiers in need of treatment and recovery services. The consequences are significant: stigma is associated with a delay or resistance to seeking treatment, the underfunding of services related to SUD care, more punitive and unaccommodating treatment in the law and in enforcement via the criminal justice system, and denial or discouragement of access to resources, such as housing, employment protections, medication assisted treatment, and other evidence-based harm reduction services shown to reduce morbidity and mortality.

B. Findings

Interviewees shared an array of stigma-driven situations. One noted an unwillingness of some area pharmacies to carry naloxone because they did not want people with substance use disorder around

²¹⁵ NATIONAL ACADEMIES OF SCIENCES, ENGINEERING AND MEDICINE, ENDING DISCRIMINATION AGAINST PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: THE EVIDENCE FOR STIGMA CHANGE 4 (2016).

²¹⁶ NATIONAL ACADEMIES OF SCIENCES, ENGINEERING AND MEDICINE, ENDING DISCRIMINATION AGAINST PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: THE EVIDENCE FOR STIGMA CHANGE 42-49 (2016).

²¹⁷ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., DEPT. OF HEALTH AND HUMAN SERVICES, IN BRIEF 9(1), CHRONIC SUBSTANCE USE AND COGNITIVE EFFECTS ON THE BRAIN (2016), available at <https://store.samhsa.gov/shin/content/SMA16-4973/SMA16-4973.pdf>.

²¹⁸ *Early Intervention, Treatment, and Management of Substance Use Disorders*, in FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH, 4-1 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/chapter-4-treatment.pdf>.

²¹⁹ *Recovery: The Many Paths to Wellness*, in FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH, 5-1 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/chapter-5-recovery.pdf>.

their facilities (an observation that appears to be paralleled in a recent study that found Indiana pharmacists in areas with higher rates of opioid overdose mortality 56% less likely to sell syringes without a prescription than in areas with lower mortality rates).²²⁰ Others noted “Not in My Back Yard” concerns arising related to siting of facilities for Medication Assisted Treatment or other harm reduction services, such as syringe exchange programs. One interviewee noted that no information is submitted into the INSPECT system concerning methadone prescriptions, casting its prescribing under a cloud. Some interviewees discussed the unwillingness of certain recovery programs, employers, and housing settings to accommodate individuals who use medications for treatment and recovery such as suboxone or methadone. Some interviewees, discussing probation and the criminal justice system, described setbacks in care being treated as intolerable; this resulted in reinstatement of sentences or expulsion from treatment programs rather than recognition that such incidents are unfortunate but foreseeable detours on the road to recovery.

The rise in physician prescription of pharmaceutical opioids for outpatient pain management is frequently noted as a key contributor to the current crisis.²²¹ Consequently, many policy initiatives adopted and proposed in response to the epidemic – including implementation of Prescription Data Monitoring Programs (PDMPs), introduction of treatment agreement regulations by the state medical board,²²² implementation of professional education mandates, and establishment of opioid dose prescribing limits²²³ – have focused directly or indirectly on regulating how pain management is addressed in the physician-patient relationship. While aimed at public safety, such efforts may reinforce negative stigmas related to Substance Use Disorder for both patients and providers. For example, efforts to discourage aberrant, drug-seeking behavior, such as frequent screenings and pill counts, pain contracts, and/or narrow dosage or pill limits, may also discourage the pursuit of treatment by patients with genuine pain concerns. Furthermore, as noted by one interviewee: while physician and other healthcare provider behavior may have contributed to the current crisis, physician and other provider education and ongoing involvement is critical to efforts to implement evidence-informed responses.²²⁴

Studies have shown that education campaigns can help decrease stigma associated with mental health and substance use disorder.²²⁵ As noted above, seeing these circumstances at base as health concerns rather than as moral failings reduces structural stigma, public stigma, and self-stigma. It also helps increase cross-sector collaboration (such as criminal justice, health care, and public health). Progress in these areas is being made. As noted optimistically by one interviewee, “People never talked about this stuff before” in multidisciplinary settings. The state’s new Next Level Recovery Website and “Know the O Facts” campaign²²⁶ can aid in the adoption of more supportive, less judgmental “person first” language when discussing the people and events associated with addiction, recovery, and treatment.

²²⁰ Beth E. Meyerson et al., *Predicting Pharmacy Syringe Sales to People Who Inject Drugs*, 56 INT. J. DRUG POLICY 46 (2018), available at <https://doi.org/10.1016/j.drugpo.2018.02.024>.

²²¹ SAM QUINONES, DREAMLAND (2015).

²²² Summer McGee & Ross D. Silverman, *Treatment Agreements, Informed Consent, and the Role of State Medical Boards in Opioid Prescribing*, 16 PAIN MEDICINE 25 (2015), available at <https://doi.org/10.1111/pme.12580>.

²²³ See, e.g., INDIANA GUIDELINES FOR OPIOID PRESCRIBING IN THE EMERGENCY DEPARTMENT, IND. STATE DEPT. OF HEALTH, available at https://www.in.gov/isdh/files/Indiana_ER_Opioid_Prescribing_Guidelines.pdf (last visited March 25, 2018); CENTERS FOR MEDICARE AND MEDICAID SERVICES, IMPROVING DRUG UTILIZATION REVIEW CONTROLS (OPIOIDS), in 2019 MEDICARE ADVANTAGE AND PART D ADVANCE NOTICE PART II AND DRAFT CALL LETTER (Feb. 1, 2018), available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-02-01.html>.

²²⁴ Sue Loughlin, *Medical Practices Changing in Face of Opioid Crisis*, INDIANA ECONOMIC DIGEST, March 19, 2018, available at <http://indianaeconomicdigest.com/Main.asp?SectionID=31&SubSectionID=91&ArticleID=91547>.

²²⁵ National Academies of Sciences, *supra* note 1, at 69-92.

²²⁶ *Next Level Recovery*, STATE OF INDIANA, <http://www.in.gov/recovery/index.html>, (last visited Mar. 25, 2018).

Campaigns that connect individuals and families with peer support, such as the Veteran's Affairs Make the Connection website, can increase pursuit of care and build connections through shared community experiences. Increasing health professional education via continuing education programs and other professional in-service activities can help demystify issues related to pain, mental health, addiction and treatment.

Several interviewees were optimistic about the effectiveness of education campaigns within their work environments that included the sharing of personal stories of the struggles of the participants, or of their friends and loved ones, with substance use disorder. As one interviewee stated, with the SUD crisis affecting so many communities, this is no longer an issue facing some nameless "drug addict," but instead, "That's your uncle, cousin, friend." These educational programs were especially useful in exploring the concepts of risk and protective factors associated with SUDs, increasing participant understanding of why some people struggle with addiction while others do not.²²⁷ They also may be useful in helping allay compassion fatigue among first responders,²²⁸ and in increasing self-care behaviors and resilience within these various high stress professions responding to the crisis. Finally, some interviewees described the positive impact of education efforts that made parallels between struggles with SUD and the onset and management of adult-onset diabetes, or access to treatment and recovery medications for SUDs to access to heart medications following cardiac arrest or insulin for diabetics.

More effective than education alone in reducing stigma are initiatives that foster meaningful contact between those inside and outside the stigmatized population. A meta-analysis of 79 studies found that programs that engaged affected populations, who were able to share and personalize the information with their lived experiences, were twice as effective in improving attitudes and intended behaviors as education alone.²²⁹ This community engagement model has been highly successful in national programs delivering health services to vulnerable populations. For example, federal law requires that 51% of the members of governing boards of Federally Qualified Health Centers be consumers of the center.²³⁰ The Federal Drug-Free Communities (DFC) Support Program requires that community coalitions seeking grant funding from this program aimed at reducing youth substance abuse demonstrate representation from a dozen different sectors of the community (see figure below).²³¹ The Comprehensive Addiction Recovery Act of 2016 also aligned many of its funding priorities behind what one interviewee called a "nothing about us without us" philosophy of substantively including community members in program and local policy development.²³²

²²⁷ Substance Abuse and Mental Health Services Administration, *Risk and Protective Factors*, available at <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors> (last visited Mar. 25, 2018).

²²⁸ COMPASSION FATIGUE (CHARLES R. FIGLEY, ED.) (1995).

²²⁹ Patrick W. Corrigan et al., *Challenging The Public Stigma of Mental Illness*, 63 *Psychiatric Services* 963 (2012), available at <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201100529>.

²³⁰ Brad Wright, *Who Governs Federally Qualified Health Centers?*, 38 *J. Health Polit. Policy & Law* 27 (2013), available at <http://doi.org/10.1215/03616878-1898794>.

²³¹ UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, REPORT GAO-17-120, DRUG FREE COMMUNITIES SUPPORT PROGRAM (2017).

²³² E.g., Comprehensive Addiction Recovery Act of 2016, Public Law 114-198, secs. 302, 501.

Drug-Free Communities (DFC) Support Program: Required Coalition Members



As stated by some of our interviewees, this form of engagement with the community of individuals and families directly affected by substance use disorder (as contrasted with “token” representation or “box checking” outreach) fosters trust within the at-risk community, which increases the likelihood of making stronger connections with treatment and recovery programs and services. Such engagement also increases the likelihood that proposed policies and programs will be responsive to the needs of the affected population. As stated by one interviewee from criminal justice, hearing from those directly affected by Substance Use Disorder is a “reality check” for those engaged in community program and policy response efforts, as many others around the table “haven’t walked that walk or lived that lifestyle.” Another interviewee described examples of effective inclusion of those with lived experiences on community agencies, policymaking bodies and oversight boards, such as Local Coordinating Councils (LCCs). Currently, for LCCs, Indiana policy only requires the inclusion of community members if the council also is a grantee under the federal Drug Free Communities Support program (which funds community efforts to prevent or reduce youth substance abuse) or wish to apply for such grants.²³³

C. Opportunities

- Based upon feedback we heard from interviewees, education campaigns directed toward providers as well as the public on Medication Assisted Treatment and naloxone would be valuable. In July 2018, the Indiana Supreme Court, led by Chief Justice Loretta Rush, will offer an educational program on Medication Assisted Treatment to hundreds of representatives from

²³³ Indiana Local Coordinating Council Structure and Requirements Agreement, *available at* https://secure.in.gov/cji/files/G_LCC_Structure_and_Requirements_Agreement.pdf (last visited Mar. 25, 2018).

the state's local court systems, including judges, court staff, prosecutors, and public defenders. These efforts show promise of improving the knowledge, attitudes, beliefs, and evidence-informed actions of key personnel within a critical response sector. Efforts should be undertaken to measure pre-intervention and post-intervention knowledge, attitudes, and beliefs to assess the program's impact.

- State and local policymaking bodies, community coalitions, initiatives, and programs related to Substance Use Disorder treatment, care, and response should, whenever possible, include the voices of those directly impacted by SUD, including family members and current or former SUD service recipients.

CONCLUDING REMARKS

This project has identified various law and policy interventions that can support the substance abuse response in Indiana. These interventions are not meant to be an exhaustive list of promising law and policy interventions. However, none of the data we examined, our interviewees, or our original research suggest that the opioid epidemic will be controlled, never-mind ended in a short time-frame.

We recognize that, because there is no one solution to the epidemic, the federal government and the State of Indiana will continue to make incremental changes to laws and policies over the years ahead. Some of these changes no doubt will reduce the legal and policy barriers we and others have identified. Equally, some may have unintended consequences, creating new barriers. We believe that additional and continuing research is needed to further analyze the potential impact, implementation, and enforcement of these laws. Equally, the “laboratory of the states” no doubt will suggest intriguing new laws and policies that may or may not be a good “fit” for Indiana. There, too, continuing analysis will be required. We have identified several avenues for further research and analysis and look forward to continuing our work.

APPENDICES

APPENDIX A: RESEARCH TEAM BIOGRAPHIES

Nicolas P. Terry (Co-PI), Hall Render Professor of Law & Executive Director of the Hall Center for Health Law at Indiana University Robert H. McKinney School of Law. There, he teaches “Introduction to Health Care Law & Policy,” “Healthcare Quality & Safety,” and “Health Information Technology & Privacy.” Educated at Kingston University and the University of Cambridge, Professor Terry began his academic career as a member of the law faculty of the University of Exeter in England before joining the faculty at Saint Louis University School of Law. He has been a Senior Fellow at Melbourne Law School and held visiting faculty positions at various U.S. law schools. He is a well-known scholar on health law topics, nationally and internationally. His research interests lie primarily at the intersection of medicine, law, and information technology. His recent scholarship has dealt with health privacy, mobile health, the Internet of Things, social media, big data, and AI. He is broadly published in books, law review, medical and other journals. In addition to his scholarship, Professor Terry has been successful in leading in the conception, planning, and delivery of myriad interdisciplinary symposia at the IU McKinney School of Law. Terry has served on the Board of Advisors for the non-profit Patient Privacy Rights and was a member of the US Department of Health and Human Services Health IT Policy Committee’s Consumer Workgroup. In 2016, he testified before Congress on the regulation of mobile health apps. He is one of the permanent bloggers at Harvard Law School’s Bill of Health. His recent publications are at <http://ssrn.com/author=183691>, and you can find the Terry-Pasquale “The Week in Health Law” podcast at TWIHL.com.

Ross D. Silverman (Co-PI), Professor of Health Policy and Management at the Indiana University Richard M. Fairbanks School of Public Health at IUPUI, and Professor of Public Health and Law at the Indiana University Robert H. McKinney School of Law. He is a member of the Indiana University Center for Health Policy and the Indiana University Center for Bioethics. Prior to 2013, Professor Silverman served 15 years as faculty at Southern Illinois University Schools of Medicine and Law, including five years as chair of the medical school’s Department of Medical Humanities. His research addresses a wide array of subjects at the intersection of public and population health, healthcare, law, policy and policy surveillance, and ethics, with publications appearing in major journals in these fields, including the *New England Journal of Medicine*, *JAMA*, *Health Affairs*, *Science*, *Annals of Surgery*, and the *Journal of Law, Medicine, and Ethics*. He has had two recent publications in peer-reviewed journals related to Indiana opioid policy, law, and ethics, in *Pain Medicine* (doi: 10.1111/pme.12580) and *JAMA* (doi: 10.1001/jama.2015.12672). He is an investigator conducting community-engaged research and law and policy analysis for the Indiana State Department of Health *Prescription Drug Overdose Prevention for States* contract with the Fairbanks School of Public Health (D. Watson, PI). Professor Silverman is the Associate Editor on Legal Epidemiology for the journal *Public Health Reports*, the official journal of the Office of the U.S. Surgeon General and the U.S. Public Health Service.

Aila Hoss, Visiting Assistant Professor and IU Grand Challenge Fellow at Indiana University Robert H. McKinney School of Law. Her research explores topics in public health law, health policy development, and the impact of federal Indian law and Tribal law on health outcomes. Prior to joining the faculty at IU, Aila served as a staff attorney for the Centers for Disease Control and Prevention’s Public Health Law Program (PHLP), where she worked to improve public health through the development of legal tools and the provision of legal technical assistance to state, Tribal, local, and territorial governments. This included supporting the agency’s Ebola Emergency Operations Center and responding to legal research requests related to the Zika virus. Aila has published on a variety of health law topics in the *Journal of*

Law, Medicine and Ethics, the Journal of Public Health Management and Practice, and the CDC's Morbidity and Mortality Weekly Report, among others, and has presented at national conferences including the Public Health Law Conference and the National Indian Health Board Public Health Summit. Aila serves as a faculty member for CDC University's Working Effectively with Tribal Governments course and has previously served as a member of the Expert Review Workgroup for the CDC's Legal Epidemiology Competency Model Project.

Rebecca Critser, JD/MA candidate IU Robert H. McKinney School of Law, Indiana University Purdue University – Indianapolis. Her research explores the intersection of law and ethics and has published on topics related to end-of-life care. She currently serves as a law clerk with Indiana Legal Services, working on the LGBT and Medical Legal Partnership Projects. She previously worked for Cook Group in the area of quality assurance. She earned her BS in Animal Behavior from Bucknell University and will be sitting for the Indiana bar in July 2018.

Emily Beukema, JD/MPH candidate Indiana University Robert H. McKinney School of Law, Indiana University Richard M. Fairbanks School of Public Health. Her research interests lie in health law and policy, specifically, access and affordability of care. She earned her Bachelor of Science in Biomedical Sciences from Western Michigan University and was first introduced to health law while working in a clinical setting as a medical scribe.

Catherine Sterling, MPH candidate IU Richard M. Fairbanks School of Public Health, Indiana University Purdue University – Indianapolis. Her research interests include peoples with co-occurring SMI/SUD, as well as individuals experiencing homelessness. She currently is a Grant Specialist with the Health and Hospital Corporation of Marion County and oversees awards received by Eskenazi Health Midtown Community Mental Health and Indianapolis Emergency Medical Services. Her grant experience lies in federally funded awards, post-award coordination, and writing. She earned her Master's in Public Affairs with a concentration in nonprofit management and a BA in English with a concentration in public and professional writing from IUPUI and Indiana University Bloomington, respectively.

APPENDIX B: DISCLOSURE TO INTERVIEWEES

Interviewees were provided with a “Study Information Sheet” that provided details about the study and the limited degree of confidentiality that could be guaranteed.

IRB STUDY #1712454963

INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR

“Legal & Policy Best Practices in Response to the Substance Use Crisis”

You are invited to participate in a research study regarding law and policy interventions for responding to the substance abuse crisis in Indiana and across the country. You were selected as a possible subject because of your expertise on topics related to the prevention, treatment, and response to substance abuse and addiction. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Ross Silverman (IU Fairbanks School of Public Health), Nicolas Terry, and Aila Hoss (IU McKinney School of Law). It is funded by Indiana University Grand Challenge: Responding to the Addictions Crisis.

STUDY PURPOSE

The purpose of this study is to develop evidence-based and evidence-informed recommendations pertaining to the content and implementation of Indiana and Federal laws and policies affecting local, state, and federal response to the substance use crisis. These recommendations will be informed based on information received from key informant interviews with individuals with expertise on this topic.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will participate in an interview to be held in-person, via video conference, or telephone conference call. During this interview, you will respond to a series of general and typically open-ended questions. At least two but as many as four study personnel will attend and administer this interview. We will take notes on your responses and the conversation will be recorded for possible transcription. We will use your comments to inform our proposals and recommendations, which may be published in reports or other publications. In our proposals or recommendations (or in any other contexts) we will not attribute any particular views, opinions, or other information to individuals by name.

RISKS AND BENEFITS

The risks of participating in this research are being uncomfortable answering the survey questions. There is also a risk of loss of confidentiality. Benefits of the study include informing law and policy interventions to respond to the substance abuse crisis.

CONFIDENTIALITY

While your interview responses will inform our proposals, recommendations, and publications, we will not attribute any particular views, opinions, or other information to individuals by name. For example, in a publication we might state: “two of three legal experts interviewed recommended broadening immunities for “Good Samaritan callers” or “one senior law enforcement official interviewed expressed serious doubts about the effectiveness of specialty courts.” Notwithstanding, this phase of our study will involve a relatively small number of well-known expert informants and it is possible that a reader might infer your actual identity from such text.

Only the principal investigators, key personnel, and student researchers will have access to interview recordings and transcripts. They will be retained for three years following completion of the study. Notwithstanding, there are organizations that may inspect and/or copy research records for quality assurance and data analysis including the Indiana University Institutional Review Board or its designees.

PAYMENT

You will not receive payment for taking part in this study.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study, contact the researcher, Ross Silverman, at (317) 278-3776.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with Indiana University.

APPENDIX C: SAMPLE QUESTIONS

General Questions

1. How would you describe the scope of the substance use problem (in Indiana, elsewhere, and/or generally)?
 1. How does your professional role(s) intersect with these concerns?
2. To [you or your constituents] what would success look like regarding the opioid crisis [e.g., end of use of illegal drugs or treatment for users, or...]
3. For you, what would constitute a successful law or policy intervention in the Substance Use Crisis?
 1. By what metric or measure would you assess the success or failure of the intervention?
4. Can you identify legal or policy initiatives that have been successful in addressing the substance use problem?
 1. Are these successes national, regional, or local?
 2. Can you identify the evidence base(s) for these successful interventions?
 3. What do you believe contributed to the success of these initiatives?
 4. Do you believe such success(es) can be replicated elsewhere and, specifically, in Indiana?
 1. If so, how?
 2. If not, why not?
5. Can you identify legal or policy initiatives (or the implementation/interpretation of laws/policies) that have inhibited evidence-based responses or interventions in Indiana/for Indiana residents?
 1. Are these barriers federal, state, regional, or local laws or policies?
 2. Can you identify the evidence base(s) for the conclusion that these legal or policy initiatives have created barriers to successful interventions?
 3. What recommendations/examples do you have for how to successfully overcome such barriers?

Domain-Specific Questions (Examples)

1. Significant work coming out of state courts initiatives and some new funding are concentrating on Medication-Assisted Treatment (MAT). From your perspective can you evaluate the level of available treatments in your []
2. Would you like to make any other comments on MAT or more broadly on harm-reduction naloxone, etc.

.....

1. Please unpack the [prisoner] “re-entry” issue for us (e.g., housing, healthcare, jobs, food, stigma...).
2. How would you rank these as far as level of risk for those facing re-entry, particularly if they have a history of addictions?
3. We know that the individuals being released from the criminal justice system are particularly vulnerable. Can you speak to the continuity of care between the criminal justice system and legal reentry? Can you speak to persons being released from DoC and how they are reconnected to services such as Medicaid?

.....

1. Turning to legal and regulatory issues.... What are the real or perceived legal barriers to improve data sharing of opioid-related data?
2. Specifically, can you speak to the relationship between the HIPAA privacy rule and 42 CFR Part 2. Way forward?